AN EXAMINATION OF THE EFFECTIVENESS OF COUNSELING AS A FUNCTION OF SOCIOECONOMIC STATUS AND GOAL CONGRUENCE

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the Faculty of the

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Doctor of Theology

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by

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This dissertation, written by

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PREFACE

The counseling disciplines have recently been forced to take a defensive position to try to demonstrate that counseling has positive effects on mental health. In defending itself the counseling disciplines have employed research to isolate the counseling factors which help restore mental health. The research has also noted both the pressures that undermine mental health and the groups of persons who appear to be most and least helped by psychotherapeutic intervention. It has been noted that the poor suffer a double handicap in being more likely to become ill and in being less likely to benefit from psychotherapy. The pressures from rapidly changing social and political orders as well as the personal and community disorder exert stresses upon individuals. The unequal distribution of these pressures appear to be responsible for the disproportionate percentage of mental illness in the lower socioeconomic status groups. Therefore, counseling must become aware of both the way socioeconomic status is related to mental health and the need for a variety of counseling techniques to aid a wider cross-section of the population.[1]

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[1]Don S. Browning, "The Challenge of the Poor," *Pastoral Psychology*, XIX:182 (March 1968), 5. Browning challenged counseling to acknowledge and overcome its middle-class orientation: "American religion and American psychology largely have been middle-class institutions. All of the helping professions--and this certainly includes both psychiatry and the professional pastoral care movement--are presently going through the crisis of what this admission really means. The crisis and the consequent broadening of the self-identity which it has induced can appropriately be called 'revelation.' And as is the case in every instance of revelation, this crisis both judges us and affirms us--both humbles us and makes us strong. Many of us have felt threatened by the

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This paper will review the recent contributions on the relation of socioeconomic status and mental illness. Emphasis will be placed upon the assumed relevance of counselor-client goal congruence as a variable affecting the effectiveness of counseling. One of the major conclusions to be drawn from the results of the literature and of the research is that in order to be effective in different socioeconomic status groups the counseling disciplines will have to develop and implement a variety of counseling goals and styles through which the best results for each individual can be obtained. The use of multiple counseling goals and styles can be applied to the field of pastoral counseling as it endeavors to evaluate the contribution it can make to a larger cross-section of the population than it now serves.

A debt of gratitude is owed to the members of the dissertation committee whose ideas, suggestions and criticisms made this paper possible. In particular, John McConahay, as chairman, took responsibility for guiding the project as well as for supervising the development of the instrument to ascertain counselor-client goal congruence. Howard J. Clinebell suggested the importance of a socioeconomic status for pastoral counseling. Allen Moore suggested studying the relationship of goal congruence and therapeutic success and indicated the importance of the concept of change agent as it can be applied to the work of the

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inadequacy of our traditional methods of care when applied to the poor. But when one confronts this crisis and broadens one's ministry to address the needs and styles of the underprivileged, one feels stronger for the experience. . . . If the pastoral care movement can honestly take seriously the special problems of the poor, it will be a superior movement, both humanly and professionally, because of the encounter."

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church through pastoral counseling. Frank Kimper helped clarify the implications of the goal congruence concept for pastoral counseling.

The research would not have been possible without the cooperation of the staff of the Family Service Association of Pomona. Sidney Tice, the executive director, gave approval to conducting the research in his agency. Mrs. Jack Overturf and Sidney Tice counseled a number of the sixty individuals included in the research. Mrs. Lou Quinn graded the tests and coordinated the accumulation of all the relevant material for the research.

Mr. Dick Denton of the library contributed to the dissertation by proofreading it for style and by correcting the notations. Mrs. Barbara Henckel typed the dissertation as carefully as if it were her own and corrected a number of my errors while typing the final draft. I should like to express my appreciation to all of the persons mentioned who by their assistance and consideration made it possible to complete this dissertation.

Behind every man who endeavors to write is a family that wonders if he will ever finish. Judy and our children, Deborah and David, have supported me by their continued understanding and affection.

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TABLE OF CONTENTS

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Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF TABLES

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CHAPTER I

INTRODUCTION AND DESCRIPTION OF THE CONDITIONS OF POVERTY

Pastoral counseling, as well as the more inclusive field of mental health disciplines, finds itself in a position analogous to the little boy who tried to plug the dike and hold back the flood of the North Sea. The task of saving people from the flood tides of mental illness is far more difficult because it appears the mental health worker is trying to plug a sieve--the destructive pressures of life stress break through on all sides. The destructive stresses discussed in the counselor's chambers impinge upon the client at home, in school, in his work, with friends, in his role in society; in short, society casts its waves upon the individual at every moment of his existence. The challenge for the mental health worker is not limited to patching the person who has been damaged by the stresses of life. The mental health movement should find ways to change society so that the destructive stresses can be reduced. Further, we need to devise improved techniques to understand and overcome the effects of inordinate life stresses.

The goals of the research reported in this dissertation are to examine the effect of life stresses as a function of the client's position in the American socioeconomic status structure, to evaluate the effectiveness of counseling as a function of counselor-client goal congruence, and to suggest the importance of the findings for both further research and for implementation in the field of pastoral counseling.

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Chapters two through four will examine the two independent variables (socioeconomic status and goal congruence) and the dependent variable (effective counseling). These three variables comprise the skeleton for this body of research on the effectiveness of counseling. This chapter will attempt to describe the effect of the stresses of socioeconomic status upon individuals.

I. SOCIOECONOMIC STATUS

The American Dream of a classless society in which every person has an equal opportunity to succeed is in reality only a dream, an illusion. Although they are not clearly defined, America has implicit classes. The Dream of equal opportunity has had the effect of blinding the field of psychotherapy to the challenge to evaluate the effects of socioeconomic status upon individuals and families. It is time to awaken from dreaming.[1]

Poverty Rediscovered

Since 1960 an interest in socioeconomic classes has developed as a concomitant of concern about poverty in the United States. As recently as a decade ago poverty was popularly regarded as only an

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[1]James R. Harris, "Poverty, Mental Health, and the Church," *Pastoral Psychology*, XX:198 (November 1969), 45-48. Harris commented that the church and psychology seem to be better able to understand each other than they understand the problems of the lower classes; and Howard J. Clinebell, Jr. and Harvey Seifert, "Interdependence of the Pastoral and the Prophetic," *Pastoral Psychology*, XX:198 (November 1969), 9. The authors issued a call to help prevent personal problems by resolving or reducing social problems.

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unpleasant memory from the dark depression days of the 1930's. John Galbraith's *The Affluent Society* was mistakenly accepted as a literal description of our society.[2] Few realized the irony of the title. The task of discovering the millions of Americans lost in the grasps of poverty was left to individuals such as Michael Harrington.[3] Harrington's *The Other America* dramatically documented the extent and pervasiveness of poverty in the United States in 1960. The attention that was subsequently focused on the poor in America led to defensive arguing. While the American Dream of equal opportunity was defended, the poor remained in the background--the invisible Americans.

Ben H. Bagdikian pointed to the pervasiveness of poverty in his book, *In the Midst of Plenty: The Poor in America.*[4] Bagdikian offered a series of vignettes presenting the tragedies of persons living in poverty. He commented:

> Ironically, the native American poor of the 1960's are worse off in some ways than the foreign immigrants of two generations ago. Both came practically penniless, went to the worst housing, got the worst jobs, and suffered the isolation and discrimination that comes to the impoverished stranger.
>
> But the foreigners had their own culture and countrymen and history to give them assurance while they were being shunned by the new culture.[5]

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[2]John K. Galbraith, *The Affluent Society* (New York: Mentor, 1958). The revised version of this book appeared in 1969 with an increased emphasis on the plight of poverty within the affluent society.

[3]Michael Harrington, *The Other America* (Baltimore: Penguin, 1964).

[4]Ben H. Bagdikian, *In the Midst of Plenty* (Boston: Beacon Press, 1964).

[5]*Ibid.*, p. 13.

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Bagdikian stated further that our society discriminates against the poor in providing second-rate schools, second-rate employment, and second-rate housing. Discrimination is related to economic class as well as to race. The results of these discriminatory processes is the alienation of the poor. "The poor today are stranded in islands of slums surrounded by indifference."[6]

How can American society claim to have humanitarian concerns based on the Judeo-Christian faith and yet remain indifferent to the plight of the poverty-stricken in their midst? Apparently ideals and conscience have not worked to alleviate the problems. In fact the American Dream and the Protestant Ethic have been employed to justify ignoring the problems of poverty in the United States. The conspiracy has exacerbated instead of alleviated the problems. The Dream and the Ethic dismiss poverty by labeling it a stimulus which should challenge men to work harder in order to succeed. The ironic effect of this misunderstanding is that it encumbers the poor with additional stress for failure. Continued poverty is regarded as a consequence of ignorance, sloth, or the supposed fact that a healthy national economy requires a certain level of unemployment. Poverty is rarely seen as a problem to the nation, to the economy, or even to the families in poverty which struggle for basic existence.[7]

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[6] *Ibid.*, p. 25.

[7] Harrington, *op. cit.*, pp. 153-154. Harrington pointed out the economic and personal costs of not alleviating poverty: ". . . we already pay an inordinately high price for poverty in the United States. Misery generates social chaos, and it takes money just to police it,

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The Protestant Ethic has brought the Calvinistic doctrine of predestination to the defense of the spirit of capitalism.[8] The Protestant Ethic contends that the person who is poor is so only because he has not established himself as yet, or because he is not among the "elect." The doctrine has been misapplied to salve the conscience of Christians, enabling them to be unconcerned for or even critical of the poor. The more affluent criticize the poor without seeing or acknowledging society's role in creating and perpetuating (ordaining?) poverty. Insult is added to injury as the good church-going Christian turns from the sight of the impoverished slum to remind us that Jesus said, "The poor you will always have with you."

If the American Dream perpetuates an illusion, the Protestant Ethic condones an immoral avoidance of the responsibility of the more affluent to reduce the pain and the persistence of poverty. Of course the church and the mental health movement must move beyond reducing the pain and the persistence of poverty if they are serious about confronting

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just to keep it from becoming so explosive that it will disturb the tranquility of the better off. In cold cash-and-carry terms, there would be a long-range pay-off if slums were abolished in the United States. In human terms, such an action would mean that millions of people would be returned to the society and enabled to make their personal contribution."

[8]Max Weber, *The Protestant Ethic and the Spirit of Capitalism* (New York: Scribner, 1958) and Robert H. Bonthius, "A Theology of Poverty: Prelude to Pastoral Care of the Poor," *Pastoral Psychology*, XX:198 (November 1969), 21-29. Bonthius quoted a nine point satirization of the Protestant Ethic as a justification for apathy concerning poverty, e.g., ". . . we will always have the poor with us so we might as well accept it and say that's their tough luck."

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the causes of poverty rather than just covering up its painful manifestations, symptoms. The church has too long been guilty of giving charity in destructive ways that imply that the recipient is inferior or iniquitous and that the oppressive society is morally just and tolerant of the recipient.

Therefore, pastoral counseling has an obligation to work in the realms of both personal and societal realities. Illusionary dreams cannot be condoned. Christian responsibility challenges pastoral counseling toward a more effective performance in counseling with the lower socioeconomic status clients. The church, too, has the obligation to overcome its complicity in keeping the poor in their place. The church should be a change agency that transforms a sick society, as well as a good physician healing the victims of that society. With these challenges in mind this dissertation will attempt to relate the church's concern for the welfare of man to persons in need of counseling. But in order to discuss poverty we need to examine the economic guidelines established for the politico-legal description of poverty.

Economic Guidelines

The anti-poverty programs originally established a guideline that a family of four living on less than $4000 annually was living in poverty. Later considerations led to reducing the guideline cut-off point to $3000. Some programs have made slight changes in the guideline to compensate for inflation and the increased cost of living. Thus we may see the cut-off designated to be $3200 or $3400. These figures are

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not only arbitrary, they are unrealistic for most sections of the United States. The fact that millions of families do exist on less than $3000 annually does not justify setting it as a cut-off point to limit those families eligible for some government assistance.

A far more realistic figure for the poverty level in 1969 would be $5000 with a built-in increase to compensate for cost of living.[9] A number of authors, among them Myrdal and Harrington, have made the contention that the United States has the ability but not the will to end poverty.[10]

Poverty in Pomona

How many persons in the United States are impoverished? Harrington's summary of the Department of Commerce statistics stated:

> The poor in America constitute about 25 per cent of the total population. They number somewhere between 40,000,000 and 50,000,000 depending on the criterion of low income that is adopted.[11]

With one out of four Americans living in poverty we have an obligation to determine how the field of pastoral counseling can relate to

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[9] Harrington, *op. cit.*, p. 176. Harrington summarized the reports by Lampman, the AFL-CIO and the Bureau of Labor Statistics: ". . . the Bureau of Labor Statistics has produced a new budget for an urban family of four. It varies from $5370 in Houston to $6567 in Chicago, with Washington, D.C., close to an average at $6147"; and Leo Srole, *et. al.*, *Mental Health in the Metropolis* (New York: McGraw-Hill, 1962), p. 359.

[10] Harrington, *op. cit.*, p. 155; and Gunnar Myrdal, *Beyond the Welfare State* (New Haven: Yale University Press, 1960), p. 284.

[11] Harrington, *op. cit.*, p. 185; and Bonthius, *op. cit.*, p. 23. Bonthius acknowledged the difficulty in estimating the number impoverished but estimated between 25 and 80 million in the United States.

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them helpfully. The concern is urgent.

In the city of Pomona, California, where the clients for this research live, approximately 18 per cent of the population is eligible for welfare under the EYOA standard of having an annual income of less than $3000.[12] A more impassioned evaluation of the city's poverty and problems stated:

> The winds of change are blowing. The population (87,000) is changing in character. Annual population net increase, which peaked at about 4,000 a few years ago, has dropped to some 200 in 1967. A city containing 1,500 Afro-Americans in 1960 and 8,000 Mexican-Americans now estimates its minority population at 25,000 or approximately 29%. Poverty levels were estimated in 1960 at 20% in Pomona and have surely increased since.
>
> Pomona ranks 25th in the State in qualifying for Federal School Poverty Funds. Welfare, probation, school, and police problems have sky-rocketed with straining case loads, increased school discipline problems, and sharp gains in youthful crime. A recent Pomona City Police Department Report regarding youth crimes has galvanized community agencies into anxious efforts to meet the problem. The incidents of crimes of violence, narcotics, burglary, and auto theft among youth has risen sharply. The Board of Education has been forced to hire special guards to reduce vandalism at schools. Middle-class white, black, and brown families are moving out of the city, leaving 'instant ghettos' and taking their community leadership with them. Lower economic families are rapidly moving into these areas.[13]

These statistics and observations are interesting in that they seek to show the relationship of lower socioeconomic status families and increased problems in the community. The report contended that the growth of the poverty segment of the community will further enhance the

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[12]The Greater Parish Ministry Affirmative Action Program-Program Outline, 1969, p. 3.

[13]Pomona Coordinating Council, "Preliminary Report for a Youth Services Bureau for the City of Pomona," October 15, 1968, p. 2.

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need for special services and mental health approaches. There is much concurrence that the current poverty estimates of 20% of the city's population necessitate providing the most helpful services available.

The Influence of Socioeconomic Status

Socioeconomic status is an important variable in much recent research. It is more than just a passive fact about a person or a community. It exerts powerful influences on shaping the community in which the person lives, grows, and learns. Socioeconomic status often determines what stresses will be exerted upon a person. Hollingshead and Redlich's study in New Haven, although liable to the criticism that it noted only treated psychiatric disorder, was important for noting the relation of low socioeconomic status and a higher prevalence of mental illness. Langner and Michael's Midtown Manhattan study of 170,000 persons from every class sought to determine a mental health rating for every person interviewed. The results in both studies indicated that the lower socioeconomic status person is subject to more emotional pressures, has fewer stress-reducing defenses, and consequently, has a higher risk and incidence of mental illness.[14]

Langner and Michael's study is particularly helpful in its discussion of the uneven distribution of stress and strain in the distinct

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[14]Thomas Langner and Stanley T. Michael, *Life Stress and Mental Health* (Glencoe: Free Press, 1963), p. 395.

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socioeconomic groups. They isolated the stressful aspects of life and attempted to determine the degree of strain created. They called the potentially noxious factors stress. The individual's reaction to the stress was labeled strain.[15]

Langner and Michael contended that there is not an exact correlation between stress and strain. Stress is said to be relative because two sets of factors mediate between stress and strain. The first of the mediating factors is the individual's endowment, i.e., "constitutional factors, hereditary predispositions, physical, mental, and neurological 'equipment.'"[16] The second mediating factor "is the individual's positive and stressful experience, both physical and emotional, up to the time of the particular stress in question."[17]

Numerous situational experiences exert detrimental forces upon the well being of individuals. Some of the detrimental factors are: loss of a parent or any loved person, rejection by parents or peers, frustration due to minority group membership, or guilt induced by outmoded sexual taboos. These factors tend to exert pressures which mold the individual's personality. This is a particularly important point because Langner and Michael saw personality mediating between stress and strain.[18]

Langner and Michael attempted to demonstrate a process, that as an individual advances in age the stress factors increase in strength

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[15] *Ibid.*, p. 6.

[16] *Ibid.*, p. 9.

[17] *Ibid.*

[18] *Ibid.*, p. 10.

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and even tend to begin a vicious circle. A benign circle of early positive factors reinforcing and strengthening the positive factors also exists but it is so minimal that it is not noted. They further found that the effects of the stress were more destructive for individuals in lower socioeconomic classes than those in the higher classes. Therefore, the problem of poverty from the standpoint of mental health is that the stresses of life in poverty are more likely to create mental health problems. The poor face their plight with a sense of powerlessness and hopelessness. Since the problems of poverty are so pervasive we must examine the factors which restrict economic mobility upward from poverty.

II. FACTORS RESTRICTING CLASS MOBILITY

Growth-oriented Stimulation

The effects of socioeconomic status tend to perpetuate membership in the same socioeconomic class. One of the strongest factors affecting the individual is his learning experience in the home. Persons of higher socioeconomic status can afford the games, trips, and special schools that fill the child's world with wonder. Some psychologists believe that the barren conditions of lower-class homes starve the child for intellectual stimulation, creating a sensory deprivation, which has the effect of retarding the intellectual growth of the child at a most important stage in his development.[19] On the

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[19] M. Deutsch, "The Disadvantaged Child in the Learning Process,"

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other side some psychologists contend that the child in a lower socio-economic group has a very rich environment on the city streets. But before the child is old enough to venture outside of the house he is deluged with the noises of radio, television, and adult interaction--all of which may become scrambled. Intellectual stimulation of the child is one important factor affecting the developmental processes and maintaining the individual in his class of origin. Cynthia Deutsch observed:

> The slum child is more likely than the middle-class child to live in a crowded, cluttered home--but not cluttered with objects which can be playthings for him. There is likely to be less variety of stimuli in the home, and less continuity between home and school objects. Where money for food and basic clothing is a problem there is little for children's playthings, for furniture in which to store the family possessions, and for decorative objects in the home. Where parents are poorly educated, there is likely to be less labeling of objects (or of the distinctive properties of stimuli) for the child. There is less stress in encouraging the production of labels by the child and on teaching him the more subtle differentiations between stimuli (for example, knowing color names and identifying them).[20]

The lack of clearly defined growth-oriented stimulation is one factor limiting the poverty child's chances of upward economic mobility. This lack is created largely by the parents' inability to purchase the toys, take the trips, or spend the time which would help the child develop more of his potential during the early formative years. However,

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in A. H. Passow (ed.), *Education in Depressed Areas* (New York: Teachers College, Columbia University, 1963), pp. 163-179.

[20]Cynthia P. Deutsch, "Environment and Perception," in M. Deutsch, Irwin Katz, and Arthur R. Jensen (eds.), *Social Class, Race, and Psychological Development* (New York: Holt, Rinehart and Winston, 1968), p. 79.

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the lack of stimulation can also be attributed to the value system of the poverty parents.

Family Values

Values of family life are a second determinative factor in the training of the child for a particular socioeconomic class. Melvin L. Kohn focused on parental values as the important factor which helps determine how the child will perceive his environment. Persons of different classes have different conditions of life and consequently they tend to perceive the world differently. Members of different classes can be distinguished, in part, by their having "different conceptions of social reality, different aspirations and hopes and fears, different conceptions of the desirable."[21]

Much of the research of family styles and values to date has contrasted middle-class and working-class families. Kohn noted the pioneer investigation of family values and social class conducted by Evelyn Millis Duvall which characterized 'working-class'(and lower middle-class) parental values as 'traditional'--they want their children to be neat and clean, to obey and respect adults, to please adults.[22] The working-class parents have learned that economic survival for their class is dependent on conformity to externally imposed

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[21]Melvin L. Kohn, "Social Class and Parent-Child Relationships," in Frank Riessman, Jerome Cohen, and Arthur Pearl (eds.) *Mental Health of the Poor* (New York: Free Press, 1964), pp. 159-160.

[22]*Ibid.*, p. 163; and Mirra Komarovshy, *Blue Collar Marriage* (New York: Vintage, 1967).

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standards. In training their children to conform at home they guide them toward a style of life that will reduce their social mobility.

Middle-class families tend to be more attentive to their child's internal dynamics; to have more developmental values--"they want their children to be eager to learn, to love and confide in their parents, to be happy, to share and cooperate, to be healthy and well."[23] Kohn's research confirmed Duvall's findings: He found that obedience, neatness and cleanliness are valued more by working-class than by middle-class parents. Middle-class parents value curiosity, happiness, consideration and self-control more highly than do working-class parents. By way of summary Kohn stated that working-class parental values focus on conformity to external proscriptions whereas middle-class parental values tend to cluster around self-direction.[24]

The values of the poverty-class are the values of survival in a hostile environment. Survival seems to be dependent on an individuality and cleverness that are hidden from the more affluent. "Manipulation, so often mistaken as the hallmark of sociopathic behavior by middle-class clinicians, is a 'cleverness of survival' for the poor."[25] The values stressed in the family thus tend to reduce class mobility. The

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[23] *Ibid.*, p. 163.

[24] *Ibid.*

[25] Wayne Oates, "The Ethics of Poverty," *Pastoral Psychology*, XX:198 (November 1969); and Orville R. Gurrslin, Raymond G. Hunt, and Jack L. Roach, "Social Class and the Mental Health Movement," in Riessman, *op. cit.*, pp. 57-67.

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family teaches its value structure more dynamically by what it does than by what it says. Few factors have as strong an impact in the role of dynamic instruction as does family stability.

Family Stability

The third factor working to maintain the child in the same socio-economic class is family stability. The underprivileged family has many burdens. It may be prematurely broken by divorce, separation, or death; its economic conditions allow only shabby housing with further economic insecurity; and both parents are either away working or irritable when home. Yet even under these conditions many lower socioeconomic status families have stability because of the emphasis on the extended family. Furthermore, the broken home in lower socioeconomic groups does not necessarily imply family disorganization, "nor does it necessarily have the same implications for a deprived child that it might have in a middle-class home."[26]

S. M. Miller categorized lower socioeconomic status families into four subgroups by combining the criteria of economic class and family stability. He noted whether a family's economy was secure or insecure, and whether its family status was stable or unstable. This enabled him to demarcate as a typology of the poor the following family

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[26]Frank Riessman, *The Culturally Deprived Child* (New York: Harper & Row, 1962), p. 37.

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styles:

1. The Stable Poor--cell 1--is the most mobile subgroup. The children from this group are most likely of all children of the poor to advance educationally and occupationally.
2. The Strained--cell 2--is a pattern of secure economy but an unstable family. Many of the children from this subgroup are downwardly mobile.
3. The Copers--cell 3--show economic insecurity and familial stability. This subgroup also includes the downwardly mobile.
4. The Unstable--cell 4--have economic and familial instability. Miller and Cohen state that they prefer to reserve the term the "lower-class" for only this last subgroup.[27]

Miller also proposed the causes of families being in one of these poverty subgroups. Each subgroup has a style by which it struggles for existence. In the midst of the struggle the family must make do with a string when a rope is needed. Not enough time or energy remains for the expressions of approval and affection which help children develop sufficient trust in order to change their life-style or become upwardly mobile.

This is not meant to imply that middle-class families do a good job of nurturing their children. But all other things being equal the middle-class families have more opportunities and more leisure in which to reassure their children and help them develop self-confidence. Dollard and Miller have brought the larger perspective of social psychology into the framework of analytical psychology and have issued a call for a science of child-rearing:

> The slowness, the labor, and the expense of psychotherapy are evident to all, especially to patients and therapists. Analysis of the forces involved does not make it seem likely that therapists

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[27]S. M. Miller, "The American Lower Classes," in Riessman, *Mental Health of the Poor*, p. 147.

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> will hit on swift, economical techniques for treating neurotic patients. The important inference from this fact is the following: neurosis must be prevented, not cured; its waste and loss must be avoided, not repaired late in life. Since we hold that neurotic behavior is learned, we also hold that it is taught--taught unwittingly by the confused practices of child rearing in our culture. As of today, there is no science of child rearing. . . . Fad after fad sweeps the field. The parents of today weep at the thought of the pseudo-science they practiced yesterday on their beloved children. Neurotic behavior in children is dismissed as a mere incident of growth. Research is conducted in the clinic--and the home, where all happens, is neglected. Advice given to parents is mainly 'ad-libbed.' It lacks the pattern and ordering which it might have were it derived from a powerful scientific theory. It lacks the power to prevent or to predict the disaster of a severe behavior disorder.[28]

Style of Life

Lower- and working-class individuals have a life-style unique from that of the persons of higher socioeconomic status. The key concept is that the lower socioeconomic status person seeks security in a hostile environment whereas a higher socioeconomic status person is more likely to seek success in a friendly environment. Frank Riessman listed twelve themes in low income cultures:

1. Security vs. Status--the key
2. Pragmatism and anti-intellectualism
3. Powerlessness, the unpredictable world, and fate
4. Alienation, anger, and the underdog
5. Cooperation, gregariousness, equalitarianism, and humor
6. Authority and informality (not in contradiction)
7. Person centered outlook, particularism
8. Physicalism, masculinity, and health
9. Traditionalism and prejudice

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[28]John Dollard and Neal E. Miller, *Personality and Psychotherapy* (New York: McGraw-Hill, 1965), p. 428.

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10. Excitement, action, luck, and the consumer orientation
11. Non-joining
12. Special significance of the extended family. Stable, female based household.[29]

The style of life of the poor reduces the chances of upward socioeconomic mobility. Suspicion and fear of those who have "made it" makes the person in the poverty culture defensive when seeking admission to schools or employment. His style of life helps defeat his goal of advancement. The style of life of each group has the effect of keeping persons in the group they are born and raised in. Haggstrom enumerated the consequences of the psychology of poverty:

> The poor tend to have a keen sense of the personal and the concrete; their interest typically is restricted to the self, the family, and the neighborhood. There is a particular stress on the intimate, the sensory, the detailed, the personal. . . . Caught in the present, the poor do not plan very much. They meet their troubles and take their pleasures on a moment-to-moment basis; their schemes are short-term. . . . There is much egoism, envy, and hostility toward those who prosper. There is a feeling of being exploited. There are many negative attitudes and few positive ones. The unity of the poor comes about through suspicion of and resentment to powerful groups. . . . While well-to-do people tend to attribute causality to inner forces, the poor tend to make external attributes of causality, seeing themselves as subject to external and arbitrary forces and pressures.[30]

Michael Harrington extrapolated a personality of poverty from the research on poverty. He saw the citizen of the other America as rigid, suspicious, and fatalistic in outlook. "They do not plan ahead, a characteristic associated with their fatalism, lack of belongingness,

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[29]Frank Riessman, "Introduction to Part II," in his *Mental Health of the Poor*, p. 114.

[30]Warren C. Haggstrom, "The Power of the Poor," in *Ibid.*, pp. 206-207.

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friendliness, and a lack of trust in others. The middle-class observer is likely to misjudge and wrongly evaluate the weaknesses and the strengths of the poor. Harrington stated:

> Related to this pattern of immediate gratification is a tendency on the part of the poor to 'act out,' to be less inhibited, and sometimes violent. There are some superficial observers who give this aspect of slum life a Rousseauistic twist. They find it a proof of the vitality, of the naturalness of the poor who are not constrained by the conventions of polite society. It would be hard to imagine a more wrong-headed impression. In the first place, this violence is the creature of that most artificial environment the slum. It is a product of human density and misery. And far from being an aspect of personality that is symptomatic of health, it is one more way in which the poor are driven to hurt themselves.[31]

The lack of growth-oriented stimulation, the restrictive values of survival, the lack of family or community stability and the style of life all combine to perpetuate a subculture of poverty. Oscar Lewis, the anthropologist who formulated the term "culture of poverty" said:

> The culture of poverty, however, is not only an adaptation to a set of objective conditions of the larger society. Once it comes into existence it tends to perpetuate itself from generation to generation because of its effects on the children. By the time slum children are age six or seven they have usually absorbed the basic values and attitudes of their subculture and are not psychologically geared to take full advantage of changing conditions or increased opportunities which may occur in their lives.[32]

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[31] Harrington, *op. cit.*, p. 131.

[32] Oscar Lewis, *La Vida* (New York: Random House, 1965), p. xlv. Lewis stated that although there is a great deal of poverty in the U.S. there is less of what he defined as the culture of poverty, perhaps 20% of the population below the poverty line (6 to 10 million), p. li.

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Strengths of the Poor

Although we have seen descriptions and evaluations of the detrimental effects from the stresses often inherent in lower socioeconomic class membership, it would be amiss to overlook the strengths developed by the poor. Oscar Lewis commented on the positive aspects of the culture of poverty, with the caution "'It is easier to praise poverty than to live in it.'" He stated:

> Living in the present may develop a capacity for spontaneity and adventure, for the enjoyment of the sensual, the indulgence of impulse, which is often blunted in the middle-class, future-oriented man. . . . The frequent use of violence certainly provides a ready outlet for hostility so that people in the culture of poverty suffer less from repression than does the middle-class.[33]

Don Browning asserted that it is crucial that those in the helping professions become aware not only of the weaknesses of the poor, but also of their strengths. He asserted that this is important because effective help for the poor will have to involve a contribution of the wisdom and strength they have. In addition, help must be based on transforming, balancing, and supplementing those strengths. Finally, we must come to see and accept the problem of the poor as our problem. We can do this better as we acknowledge that no one class has a corner on strength or virtue.

There is reason to believe that by understanding both the strengths and weaknesses of the poor the helping professionals will be better able to render effective help.

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[33] *Ibid.*, p. li.

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> . . . in overlooking the fact that they may have developed some strengths in the way that they cope with their problems, we may fail to recognize the possible contribution they can make to a resolution of our shared difficulties. And if part of the shared problem centers in the question of the nature of man, our tendency to overlook the strengths of the poor may deprive us of the broadened and amended self-understanding of our humanity required for an adequate coping with the predicaments which harass us all.[34]

Browning stated that the strengths of the poor are often hidden in what are often labeled weaknesses, e.g., their concrete, pragmatic, action-oriented cognitive style does not make them any less interested in knowledge, rather it means their learning process should be directly associated with direct experience, and immediate problems. Although it may appear to the middle-class observer that the poor person's limited planning for the future symbolizes a lack of hope, it may indicate an enhanced ability to enjoy life in the present. Browning concluded that a dynamic interpretation of some of the so-called weaknesses of the poor should help us see them as potential strengths by means of which we will be able to find more effective means of providing help.

The material presented in this chapter documented both the effects of socioeconomic status, especially poverty, upon mental health, and the factors which tend to perpetuate a subculture of poverty. The conclusion reached is that both the church and the mental health movement must become aware of the psycho-dynamics of class membership and then find effective ways to implement the strengths of the poor in solving the mental health problems confronting them. The problem will

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[34]Don S. Browning, "Religion, Revelation, and the Strengths of the Poor," *Pastoral Psychology*, XX:182 (March 1968), 37.

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be solved only as the mental health movement recognizes that preventive community mental health which involves the poor meaningfully in the structures of power and in the solution of their problems, will be effective in eradicating some of the major causes of mental illness instead of merely alleviating some of the more blatant symptoms. This will be the background against which the following three research variables (socioeconomic status, goal congruence, and effective psychotherapy) will be projected.

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CHAPTER II

SOCIAL CLASS AND MENTAL ILLNESS

The first of the three major variables to be analyzed is socioeconomic status, especially as it relates to mental health and to mental illness. Socioeconomic status is more than an arbitrary set of criteria by which social scientists isolate segments of the total population. Richard Centers stated: "In modern societies the forms of socioeconomic stratification are various and numerous."[1] The basic forms of socioeconomic stratification are the economic, political and occupational. Centers argued that socioeconomic class membership is primarily dependent upon the class to which a person believes he belongs. Membership in a socioeconomic class is basically subjective, "dependent upon class consciousness (i.e., a feeling of group membership) and class lines of cleavage may or may not conform to what seem to social scientists to be logical lines of cleavage in the objective or stratification sense."[2]

Although our socioeconomic stratification may not comprise a rigidly defined category in which the person feels he belongs, socioeconomic position does tend to have a definite formative influence upon

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[1] Richard Centers, *The Psychology of Social Classes* (Princeton: Princeton University Press, 1949), p. 13. Centers gave as a definition of socioeconomic status: ". . . socio-economic stratification in a broad sense means simply the descriptive ordering of people into higher and lower categories with respect to some objective differential or differentia, primarily economic. . . . It is not necessarily implied that strata thus conceptually formed act or operate in society as cohesive groups."

[2] *Ibid.*, p. 27.

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"a complex or pattern of attitudes, interests and beliefs as well as to a consciousness of membership in a group which shares those attitudes. . . ."[3] Centers found this statement to be true in relation to conservatism-radicalism between large business owners and managers over against the unskilled and semi-skilled workers.

Since we shall be searching for differences between socioeconomic classes it is important to review the criteria by which other studies have designated each class. Hollingshead devised an Index of Social Position which determined an individual's socioeconomic status on the basis of (1) ecological area of residence, (2) occupation, and (3) education. A fourth factor in the evaluation was "judged class position." Each of these factors was given a scale score, and the scale score was multiplied by a factor weight determined by a standard regression equation. The three products were summed, and the resultant score was taken as an index of the individual's position in the community's class system.[4] Hollingshead presented a five step social stratification with class I representing the upper class; II, the upper middle-class; III, the lower middle-class; IV, the working-class; and V, the lower-class, or the group often referred to as the poor. Hollingshead began with the assumption that social class exists, that it is determined by a few commonly accepted cultural characteristics and that therefore

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[3] *Ibid.*, p. 107.

[4] August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness* (New York: Wiley, 1958), p. 37.

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researchers can utilize a few items symbolic of status to derive a socioeconomic status rating. By means of the criteria enumerated above Hollingshead offered his operational definition of class. Hollingshead's procedure is open to the criticism that he has placed his subjects into discrete socioeconomic status groupings while failing to measure the subjective meaning of that class rating to the individual. Furthermore, Hollingshead has failed to offer a conceptual definition of social class. He has designated who is in each grouping without describing the significant aspects of class membership.

In the Midtwon Manhattan Study, Leo Srole offered only an operational definition of social class determined by four factors: education, occupation, total family income, and rent. Srole selected these criteria because they were easily quantifiable, simple to secure, and adaptable for comparative uses in different communities.[5] The factor of rent is comparable to Hollingshead's ecological area of residence. An advantage to Srole's standard is that it incorporates more of the impact of the economic factors, i.e., income and rent paid.

In the research reported in Srole's first volume on the Midtown Study only the respondent's occupation and education were used, because

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[5]Leo Srole, *et.al.*, *Mental Health in the Metropolis* (New York: McGraw-Hill, 1962), p. 201. Srole gave the following description of the determination of the respondent's socioeconomic status: ". . . to stratify respondent's own SES on the most refined and extended yardstick available to us, we have combined his total family income and dwelling rent with his education and occupation. Each of the former two indicators was also cut into six brackets and scored on a 1 to 6 scale. The sum of the scores for the four indicators, all given equal weight, was calculated for each respondent."

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the hospital records did not contain data on income and rent. However, volume two by Langner included the more complete data of four variables: occupation, education, income, and rent--each assigned an equal weight.[6]

Minuchin, in *Families of the Slums*, attempted to include more of the psychological aspects of class (especially those aspects observed in members of the lower-class). Minuchin emphasized the differentiation between the stable and the unstable elements within the lower-class subculture. The unstable element:

> . . . although sharing certain characteristics with others in the low-income population, also shows social pathology: alcoholism, disease, mental illness, addiction, crime and delinquency, etc.[7]

I. CONCERN ABOUT THE EFFECTS OF SOCIOECONOMIC STATUS

Concern about the possible effects of society on the individual has been increasing during the last decade. Sanford optimistically prophesized both the increased involvement of social scientists in action programs and the emergence of new patterns of interdisciplinary collaboration.[8] Effective change will emerge from this concern only as the church and social agencies both collaborate and, more importantly, involve the participants in the process of change. Failure to obtain this involvement is analogous to the counselor who attempts to cure the

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[6]Thomas Langner and Stanley T. Michael, *Life Stress and Mental Health* (Glencoe: Free Press, 1963), p. 500.

[7]Salvador Minuchin, *et. al.*, *Families of the Slums* (New York: Basic, 1967), p. 25.

[8]Nevitt Sanford, *Self and Society* (New York: Atherton Press, 1966), p. xii.

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client without the involvement of the client.

The Church's Concern

The minister in the church has increasingly become involved in social action. There is the threat of a rift between the social-action oriented minister and the pastoral counselor who focuses on the individual, especially his inter-psychic and intra-familial conflicts. Of course, this conflict may be lessened as the effects of social psychology are felt in the field of pastoral counseling. Wayne Oates made an attempt to heal this rift by showing how pastoral counseling can be related to social problems. Oates began by recognizing the obstacles the minister faces as he attempts to fulfill his responsibility to the individual as well as his obligation to work for a society conducive to health for the whole man. One obstacle is that of being misunderstood by those to whom he seeks to minister. A second obstacle occurs when the minister tries to justify himself by advertising his good works in counseling and negotiating between controversial people. In either case public opinion condemns him for his efforts.[9] Oates saw the minister in his role as counselor with individuals and small groups having a three-fold responsibility in relation to social problems. The minister must facilitate communication, clarification, and anticipation. Communication demands a balance between "speaking" (e.g., preaching) and "listening" (e.g., client-centered counseling). Clarification enables

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[9]Wayne Oates, *Pastoral Counseling and Social Problems* (Philadelphia: Westminster Press, 1966), p. 19.

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the two persons or parties to understand each other more fully. Oates claimed that the prophetic pastor must develop and utilize an ability to anticipate the course of events as it will effect his parish. The ability to anticipate brings the prophetic ministry into psychological and political engagement.[10]

Oates presented a picture of the new challenges which pastoral counselors can meet. Others are far less optimistic. Peggy Way leveled the charge that the church in general and pastoral counseling in particular have placated distressed individuals and in part neutralized the ferment, the social unrest, which could have been a transforming dynamic working for a better social environment for the disadvantaged classes. Way wrote: "Pastoral counselors . . . 'valued the distance of the professional relationship at a period when others were demanding advocacy, identification with common human need, and interdependence.'"[11] Way criticized the pastoral counseling movement for

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[10] *Ibid.*, p. 34. Oates stated the imperative for the pastoral counselor to deal with the stressful social concerns: "Furthermore, the ultimate issues of social ethics are the emergency demands laid upon the practicing pastoral counselor. We grapple tactically with the problems of the unskilled laborer--black or white--and the relationship of his lack of skill to family instability. Therefore, the necessity of a strategic knowledge of social change, social class, and social ethics for the effective pastoral counselor goes without saying. Pastoral counseling cannot be done on a purely individual basis in such a way as to avoid the great evils of the world. We are in great danger among pastoral counselors of making the same mistake that the nineteenth century evangelist made: the mistake of snatching individual persons from the fires of social evil and never taking any responsibility for the proclamation of the gospel concerning the social evils themselves(p.65)."

[11] Peggy Way, "Community Organization and Pastoral Care," *Pastoral Psychology*, XIX:182 (March 1968), 35.

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its intransigent focus on individuals rather than communities. She criticized pastoral counselors' limited view of the challenges that must be faced in our society.

Social Reform

Programs for the alleviation or elimination of poverty have been proposed. The guaranteed annual income, negative income tax, and welfare programs are aimed at this goal, however far short they may fall. But there are indications that the elimination or transformation of the culture of poverty will require more than money. S. M. Miller specified the implications of the findings on poverty for professionals who would deal with the poor and their families. He asserted that a variety of programs should be implemented to deal with particular segments of the poor population. Case work must be made more flexible and adapted to the current problems faced by clients. Furthermore, social case work should aim at more than attempting to aid individuals. "Professionals and their organizations have to support and encourage action which deals with the larger American scene where poverty is being produced and maintained."[12]

In order to be more effective counseling should seek to develop a deeper understanding of the less affluent individual-in-his-community. This will help overcome the bias resulting when impoverished clients are

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[12]S. M. Miller, "Poverty and Inequality in America," in Frank Riessman, Jerome Cohen, and Arthur Pearl (eds.), *Mental Health of the Poor* (New York: Free Press, 1964), p. 14.

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evaluated by a distorted middle-class yardstick.[13]

The most effective help for the stress-ridden poor would be preventive mental health programs aimed at alleviating the social, economic, and psychological circumstances related to the breakdown of mental health.[14]

The challenge of mental illness imposes upon the church and community mental health organizations the obligation to become agencies working for a new community that produces and protects mental health. This is especially relevant in light of recent findings of the effects of poverty in particular on the etiology, diagnosis and treatment of mental illness.

II. SOCIOECONOMIC STATUS AND MENTAL HEALTH

Most therapists oriented towards the importance of family dynamics and the struggle to develop one's identity tend to think readily of the stress caused by over-protective mothers and passive fathers. They can also identify with the crises involved in struggling for acceptance by a peer group and acknowledgment by a respected authority. Even though these crises appear in all levels of society the counselor by training and background is inclined to understand them best in the middle- and upper middle-classes. His own origin in these classes is largely responsible for his greater sensitivity to persons

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[13]Jerome Cohen, "Social Work and the Culture of Poverty," in *Ibid.*, p. 134.

[14]Sanford, *op. cit.*, p. 314.

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of the same class.[15] Oates has noted this bias in pastoral counseling which assumed that persons in need of help must take the initiative by coming to an office, asking for help, and coming at appointed times for that help. This bias reveals pastoral counseling as "a prim, upper class phenomenon."[16]

The middle-class bias in counseling is further compounded insofar as mental health is defined in terms of middle-class values. The disparity in value systems may blind the counselor to the inner meaning of an event for his client. This disparity was glaringly revealed in an analysis of the value content of a broad cross-section of mental health pamphlets were observed to be roughly equivalent to the middle-class (vs. the lower-class) values.[17]

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[15]John Dollard and Neal E. Miller, *Personality and Psychotherapy* (New York: McGraw-Hill, 1950), p. 419. Dollard and Miller stated the importance of knowledge of social conditions for effective psychotherapy thus: "The therapist's knowledge of the social conditions under which the patient lives and has lived is usually considered 'intuitive,' something given and not especially trained for. Such intuitive knowledge is roughly adequate in the middle and upper classes of the societies of Western Europe and their offshoots. . . . As a result, the fundamental circumstances of child training are similar and the neurosis-producing conditions of childhood are similar. . . .

If psychotherapy is ever to be broadened from its present upper group locus in society, therapists will have to acquire more specialized knowledge of social conditions. The usual circumstance at the present time is that a middle- or upper-class psychiatrist treats a middle- or upper-class patient. . . . Psychotherapeutic results will be more predictable when the rudiments of knowledge of American social structure are taught in every American school where psychotherapists are trained (p. 419)."

[16]Oates, *op. cit.*, p. 77.

[17]Orville R. Gursslin, Raymond G. Hunt, and Jack L. Roach, "Social Class and the Mental Health Movement," in Riessman, *op. cit.*, pp. 57-67.

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Incidence and Prevalence of Mental Illness

A number of studies have indicated the disproportionate prevalence of mental illness in the lower-classes. Hollingshead and Redlich's study of the prevalence of treated mental illness in New Haven showed that the upper class is underrepresented in the population of the treated mentally ill, whereas classes II, III, IV are also underrepresented in the patient population, but not to the same degree as class I. The percentage of mentally ill patients in class V is more than double the percentage of class V persons in the population.[18] Hollingshead and Redlich also demonstrated that the diagnosis of the mental illness of the lower-class individuals was more severe than the diagnoses of the higher class individuals. The differential distribution of neurotics and psychotics by class ranges from 65 per cent of class I and II patients diagnosed as neurotic, 45 per cent in class III, 20 per cent in class IV, but only 10 per cent in class V.[19] The higher percentage of mental illness, as well as the greater severity of that illness, among the lower classes does not establish the causation of mental illness as a consequence of economic status. The discovery of statistically significant correlations does not establish etiology. Yet the studies reported have probed for the stress factors responsible for the higher prevalence of mental illness in the lower socioeconomic classes.

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[18] Hollingshead, *op. cit.*, p. 198.

[19] *Ibid.*, p. 222.

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Etiology

The mental health professions can no longer remain uninformed of or unconcerned about the relation of stressful socioeconomic conditions and the hazards to mental health. Although social stress may not be an obvious cause of mental illness, it has been demonstrated as a significant factor in the etiology of mental illness.[20]

Diagnosis

A further disadvantage is experienced by the lower socioeconomic class individual who becomes mentally ill. Middle-class bias tends to describe his illness as more severe than it would for a higher socioeconomic status individual with the same symptoms.[21] The diagnosis applied to the individual would, of course, affect the treatment he received and the chances of improvement.[22] While it could be argued that these observed differences make sense in light of lower-class values and beliefs in the medical cause and cure of mental illness, Hollingshead and Redlich try to make clear their conviction that the differences are tantamount to inequalities in the treatment of the poor. Their argument is strengthened by the reduced expenditure of time and money in the treatment of the poor.

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[20]Langner, *op. cit.*, pp. 484-485.

[21]Hollingshead, *op. cit.*, p. 225.

[22]William Haase, "The Role of Socioeconomic Class in Examiner Bias," in Riessman, *op. cit.*, pp. 241ff.

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Treatment

Hollingshead and Redlich postulated a relationship between socioeconomic status and treatment received. The apparently random assignment to the type of therapy prescribed raised a serious question concerning the value of diagnosis and the therapy offered, however, the relation between socioeconomic status and treatment was significant.[23] They found further that the place where neurotic patients first received therapy was related to class status, rather than psychiatric diagnosis. Upper-class persons went to private practitioners, middle-class persons went to private and public agencies, and the poor went to public agencies.[24]

The type of therapy given to the neurotic patients was also related to social class. Only upper-class persons received psychoanalysis. The lower-class individuals were more likely to receive directive therapy. Lower-class neurotic patients were five times as likely to receive organic therapy as were the upper-class neurotic patients, and custodial care was limited to the lower-class.[25]

In comparison to the apparently indiscriminate assignment of neurotic patients to types of agencies and treatment modalities they found that diagnosis was related to the type of therapy the psychotic

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[23]Hollingshead, *op. cit.*, pp. 259-260.

[24]*Ibid.*, p. 261.

[25]*Ibid.*, pp. 266-267.

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patient received.[26] However, even the lower-class psychotic patient feels the inequality of his treatment. Less time and money per patient were invested on the lower socioeconomic status psychotic patients than those in the higher socioeconomic classes.

The crux of the mental health problem for persons of lower socioeconomic status is that stress factors tend to aggravate a higher proportion of mental illness, which appears to be more severe. Yet the treatment available for the lower socioeconomic status patients is inferior to that offered to higher socioeconomic status patients.

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[26] *Ibid.*, p. 288; and Norman Q. Brill and Hugh A. Storrow, "Social Class and Psychiatric Treatment," in Riessman, *op. cit.*, pp. 68ff.

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CHAPTER III

GOAL CONGRUENCE

This chapter will focus on what is perhaps a new concept in the area of pastoral counseling, the concept of goal congruence. Conceptually, goal congruence is the degree of cooperation between the counselor and client. This cooperation is based on the mutual understanding and respect of counselor and client. It implies that the counselor is often able to perceive the client's goal. If the goal is one of many in the counselor's repertoire of counseling skills he can enter into a therapeutic contract to help the client in the way he has chosen. Operationally, goal congruence will be used to signify the degree of agreement between counselor and client on thirteen statements describing goals and five techniques of counseling. High goal congruence signifies close agreement on the goals and techniques of counseling; low goal congruence signifies a relatively lower degree of agreement.

I. GOALS OF PSYCHOTHERAPY

One of the two major hypotheses of this study is that the degree of improvement during counseling is positively correlated with the degree of congruence of counselor and client on the goals of counseling. The word "goals" is used rather broadly to include preferred outcome and the preferred modality of counseling to produce the preferred outcome.

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Traditional Goals Inadequate

Traditionally, the individual entering a psychotherapeutic relationship has been expected to learn a new "language" by which to communicate his feelings to the therapist. Failure to abandon the everyday style of communication as well as the unwillingness to place one's values in a psychological limbo during the counseling process has been interpreted as defensive resistance. To the degree that client and/or counselor are unwilling to overcome this gap, a failure to communicate is perpetuated. The client disturbs the counselor. The counselor is inclined to dismiss the client as unmotivated. The counseling process comes to a quick end, if indeed, it ever had a real beginning. We have reason to believe that many clients of lower socioeconomic status never really move from their interview to an involvement in the psychotherapeutic process. They distrust the counselor, question his way of working, and remain skeptical that he can help them. Communication between client and counselor is established only very tenuously.

Hollingshead and Redlich found that the neurotic patient's knowledge of psychiatry was inadequate in every socioeconomic class.[1] Furthermore, the difficulty in communicating emotional problems disproportionately affects the lower socioeconomic classes.

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[1]August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness* (New York: Wiley, 1958), p. 339.

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> It is difficult for patients in every class to explore their emotional problems. But less than 2 per cent of the class V patients understood the aims or techniques of psychotherapy. Over 90 per cent of the class IV patients remained so upset that real participation in exploratory psychotherapy was never possible. Even among the class III's who were able to talk about their problems there were some who never grasped the meaning of psychotherapy and hoped that after 'all the talking' comes the 'treatment.' In some patients, this hurdle is never overcome.[2]

The lower socioeconomic class neurotic patient's failure to understand the process of psychotherapy is not merely defensive resistance. The counselor and the client live in different worlds.[3] Neither understands the other adequately to help him or be helped by him. If the problem was primarily resistance we would expect the passage of time in counseling to allow the counselor to help the client to work through the resistance. But time does not close the gap.[4]

Only classes I and II are inclined to understand intellectually and emotionally, the concept of psychogenic etiology of mental illness. "Class IV and V family members regard mental illnesses as somatic diseases and think they are caused by such things as 'bad blood,'

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[2] *Ibid.*

[3] *Ibid.*, p. 334. The authors stated: "The most frequent source of difficulty between the lower status patient in psychotherapy and the therapist is the patient's tacit or overt demand for an authoritarian attitude on the part of the psychiatrist, and the psychiatrist's unwillingness to assume this role because it runs counter to certain therapeutic principles. 'Insight' therapy is less likely to be grasped by lower class patients than physical therapy or a therapy employing 'magical methods.'" (p. 345) Authority and the medical expectations constitute the magic anticipated by lower socioeconomic status clients.

[4] *Ibid.*, p. 340.

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'a bump on the head,' and 'too much booze.'"[5] Thus the agency or counselor that wishes to be helpful to the lower socioeconomic status client to comprehend the etiology of mental illness or the psychotherapeutic process. The comparison of the witch doctors, faith healers, placeboes, and brain washing to psychotherapy may move from the humorous to the instructive as we seek new modalities in psychotherapy.[6] There is a great need to overcome the communication gap which deprives the lower socioeconomic status clients of the help they need and want.

Expectations of Psychotherapy

Overall and Aronson studied 40 lower socioeconomic status adult outpatients to determine their expectations in psychotherapy. They noted the high degree of patient attrition after the first interview in agencies serving lower socioeconomic status clients. They hypothesized that the lower socioeconomic status clients' minimal involvement (because of his distorted conceptions of mental illness and of the psychotherapeutic process) in counseling was a major obstacle to his continuing in counseling.[7]

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[5] *Ibid.*, p. 341; and Betty Overall and H. Aronson, "Expectations of Psychotherapy in Patients of Lower Socioeconomic Class," in Frank Riessman, Jerome Cohen, and Arthur Pearls (eds.), *Mental Health of the Poor* (New York: Free Press, 1964), p. 81. Overall and Aronson question Redlich's finding and stated: ". . . these patients do generally anticipate that psychiatric issues will be raised."

[6] Jerome David Frank, *Persuasion and Healing* (Baltimore: John Hopkins Press, 1961).

[7] Overall, *op. cit.*, pp. 76ff.

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Overall and Aronson found that the discrepancy between the client's expectation and evaluation of therapy was a better predictor of return to counseling than was the discrepancy between the client's expectation and his counselor's perception of the interview. When this observation is related to the socioeconomic status attitude differences on mental illness we can anticipate "an inverse relationship between the accuracy of expectations of psychotherapy and social class. . . ."[8]

Rachel Levine examined the problem of agencies' failures to serve persons because of inadequate staff and funding to serve all persons according to the current procedure. The agencies' failures are only partly hidden by placing new applications on a long waiting list.[9] Levine tried to serve more persons by devising a principle of limited goals based on three conditions: 1) The patient and therapist initially define the goal and therefore the length of treatment; 2) The therapist provides therapy intended to procure the goal desired by the patient; and 3) The patient is involved in the process of evaluating his progress

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[8] *Ibid.*, p. 84. The authors postulated: "1. Patients of lower social class expect the therapist to assume an active, medical role in the initial interview. 2. The actual conduct of the therapist during the interview is less active and medically oriented than the patient expects. 3. Those patients whose anticipations are less accurate will be less likely to return for further treatment; that is, those patients who do not return for treatment will have a greater discrepancy between their expectations and their perception of the interview. 4. The discrepancy between a patient's expectations and his perception of the interview is a better predictor of return to treatment than is the discrepancy between a patient's expectations and the therapist's perception of the interview." (p. 77)

[9] Rachel A. Levine, "A Short Story on the Long Waiting-List," in Riessman, *op. cit.*, p. 271.

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toward his desired goal and termination.[10] These steps can optimally increase the client's understanding of and involvement in the process of counseling. Levine found that the new procedure had salutary effects. It decreased the mystery surrounding treatment in a mental health clinic, allowed expression of the client's choice in problem solving, and tended to involve the patients in the process of accomplishing their own goals.[11] Levine's approach to having no waiting list at the agency led to the adoption of patient-centered goals; that is, goals which are:

> . . . understandable to the patient, and hence attainable, clearly specified, rather than the therapist's preconceived goals, generalized in terms of speculations on potentials of attainability. Patient-centered goals derive from accurate assessment of patients' immediate problems, needs, capacities for change, as well as the best way they can make use of help.[12]

Levine applied her findings to the need to diagnose by wider criteria than just psychiatric nomenclature. The diagnosis should also include an "assessment of social, cultural, educational, economic, and clinical determinants. . . ."[13] The more comprehensive diagnosis of the individual can be used to prescribe a wider range of services:

> Within a range of time-limit possibilities it is known that some patients need and can use only brief service, whether it is directed toward concrete supports like help with household management, housing, nursery school or recreation placement of children, or toward correcting misconceptions and destructive patterns of child rearing; other patients can benefit most from treatment focused on environmental change, others from psycho-

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[10] *Ibid.*, p. 273.

[11] *Ibid.*

[12] *Ibid.*

[13] *Ibid.*

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> therapeutic treatment of short duration to rebuild defenses which may have temporarily broken down in a crisis situation, others from modified insight therapy, still others from intermittent periods of supportive contact.[14]

II. PREFERRED OUTCOME

The preferred outcome of therapy as an aspect of the counseling goal has at least three modes: attitude change, behavior change, and situation change. Attitude (affective rather than intellectual) change would include the more traditional, insight-oriented, approaches intended to help the client become aware of his true feelings and gain a deeper awareness of the significance of the way he has been acting, which can, ideally, free him to live a more reward-filled life. Almost all therapeutic approaches, with the notable exception of behavioristic schools, include this first goal of helping the client become aware of his attitudes towards the end of changing them. This goal assumed that changed feelings lead to changed behavior.

Behavior change is oriented toward discussing problems in the client's life and suggesting how the client can do some things to improve his situation. Part of the change process may be attributed to insight into one's personal psyche, his relationships, or his defenses. The interaction includes the client's responses. Counselor and client can then search for new approaches which the client can implement in his life. This approach is an outgrowth of Harry Stack Sullivan's Inter-

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[14] *Ibid.*, p. 274.

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personal Relations approach[15] as well as the schools of "reality therapy."[16] More recently it has been utilized by Erich Berne who suggested that transactional analysis shows that the complaining person is in reality playing a game.[17] The counselor must become aware of the subtle underdog (martyr) games of manipulation played by clients who complain of the way they are treated but refuse to acknowledge their responsibility in the painful interactions.[18] Behavior change may be effective whether or not the person realized the significance of his change. An illustration might be the overly protective mother who complains that her teen-ager is rebellious. The counselor suggests a specific way that the mother demonstrate trust in the teen-ager. Often the improved feelings evolving from the improved way of acting provides a more solid foundation for further counseling or obviates the need for counseling, either of which would be acceptable.

Situation change as a goal assumed that the untoward pressures of home, school environment, work mileau, etc., are largely responsible for the client's distress. The client appears to be not ill but distressed by the situation he finds himself in. In some cases the client can benefit by having calm counsel on the distressing situation. The

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[15]Harry Stack Sullivan, *Conceptions of Modern Psychiatry* (New York: Norton, 1940). Sullivan's Inter-personal Relations approach is highly dependent upon the insight gained through the analysis of relationships.

[16]William Glasser, *Reality Therapy* (New York: Harper & Row,1965).

[17]Erich Berne, *Games People Play* (New York: Grove Press, 1964).

[18]Everett Shostrum, *Man the Manipulator* (Nashville: Abingdon Press, 1967).

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working student may find his situation more tolerable after reducing his course load or reducing his work load. In either case these changes would hinge on the counselor's ability to help his client find ways of constructively improving his situation. A great amount of social case-work involves improving the situation and referring the client for depth psychotherapy only if he subtly sabbotages constructive changes, or if his situation is unimprovable, in which case he might benefit from supportive counseling to facilitate his acceptance of the situation.

III. COUNSELING APPROACH

A second category for determining the degree of goal congruence was the factor of the preferred counseling approach or modality. Overall and Aronson suggested five categories to represent the aspects emphasized by Hollingshead and Redlich. The categories are: 1) Active --the counselor instructs or directs the client; 2) Medical--the counselor stresses the organic or physical problems of the patient; 3) Supportive--the counselor avoids emotionally charged material and attempts to comfort the client; 4) Passive--the counselor allows the client the right to select what he wished to discuss; and 5) Psychiatric --the counselor stresses emotional and dynamic material.[19]

Obviously, each mode of counseling is aimed at a particular outcome. Active, directive counseling aims at providing help by having

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[19]Overall, *op. cit.*, p. 78.

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the client accept the authoritative instructions of a trusted counselor. Medical or objective modes of counseling would look for the organic causes of distress and prescribe changes to obtain improvement. This would include the counselor's dispassionate investigation of the client's eating and sleeping habits, with the prescription for a balanced diet, vitamins, exercise, and regular hours. It would also include the non-medical counselor's referring of the client to a psychiatrist or physician if it appeared the client might need medication. Supportive counseling is intended to help the client maintain his present level of psychic integration during a time when depth counseling and situational change are contra-indicated. Supportive counseling might be given for the older client, for the more rigid client, for the client slowly resolving a loss, etc. Passive, client-centered modes of counseling intend to bring improved feelings through improved insight. The psychiatric style of counseling would include approaches aimed at insight, approaches aimed at improving interpersonal relations. The psychiatric mode would include most approaches emphasizing intra-psychic and interpersonal dynamics. The broadest definition of its intended outcome would be the improved ability of the person to cope with his own emotions, and to relate to the persons he finds important in his life.

IV. LENGTH OF COUNSELING

A third aspect of goal congruence would be the determination of how long counseling would have to continue in order to be effective. The variations are from short term (e.g., crisis-intervention being

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probably the shortest duration of any approach) to long term--or even interminable. Some research on short term counseling has tried to constructively utilize the time-limit approach. This was a bold innovation when Otto Rank opposed it to Freudian analysis. Rank sought to utilize the birth trauma in his time-limited approach. Rank's most devastating attack on established psychoanalytic theory came with his publication of the *Trauma of Birth*. In this volume dedicated to Freud, Rank introduced a mother-centered conception of fear, anxiety, dependency, and insecurity. He contended that the birth trauma was more important than the Oedipus complex as a source of emotional disturbance.[20] Rank was helpful in focusing on the importance of the time invested in counseling, especially as the client works through the significance of setting his own goals and accepting the responsibility for achieving them.

The research reported in this dissertation utilized the concept of counselor-client goal congruence. This concept appears to be similar to the one in Overall and Aronson's fourth hypothesis: "The discrepancy between a patient's expectations and his perception of the interview is a better predictor of return to treatment than is the discrepancy between a patient's expectation and his therapist's perception of the interview (italics omitted)."[21] Therefore we must be observant of the relation of the counselor-client goal congruence and

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[20]Otto Rank, *Trauma of Birth* (New York: Harcourt, Brace, 1929).

[21]Overall, *op. cit.*, p. 83.

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the client's return to and continuation in counseling.

In the last chapter we viewed material on the relation of socio-economic status to mental illness and to the ability to benefit from counseling. This chapter has reviewed some of the material on the new approaches at more effective counseling based on goals that are mutually acceptable to the counselor and to the client. I have coined the term goal congruence to designate the degree of agreement and cooperation between the counselor and the client. In the research reported in this dissertation goal congruence will be one of the two major variables related to effective change through counseling. The next chapter will review the literature on effective change through psychotherapy and then it will attempt to define the criteria by which the research in this dissertation will assess therapeutic change.

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CHAPTER IV

EFFECTIVE PSYCHOTHERAPY

I. DIFFICULTY IN USING THE CONCEPT OF SUCCESS

The most difficult part of the research reported herein is the designation and description of effective psychotherapy. Basically, psychotherapy would seem to have been effective if it fulfilled the client's goals in about the time he hoped it might. But even this attempt at a definition merely brings an awareness of problems. Is it possible to know if it was the psychotherapy and not other factors, e.g., the passage of time, which is responsible for the change? Attempts have been made to evaluate the client's personality objectively before and after counseling. But tests measuring personality variables fall short of the objectivity to which they aspire. The client's emotional state while taking the test has a marked effect on the results. If one tries to ascertain the client's success in handling life situations, one cannot be sure that the report is not subjectively biased.

Carl Rogers' Contributions

There are enough unanswered questions about psychotherapy to make us ask if we are justified in trying to use the concept of success in regard to the process of psychotherapy. Carl Rogers discussed the difficulty in designating success as improved feelings or improved personal adjustment, as a cure for mental illness, etc. Rogers stated some of the problems in evaluating the results of therapy:

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> The consequence of this use of criteria based upon value judgments has been that each investigator endeavors to prove that therapy does produce certain changes which have value to him, a rather unsatisfactory basis for science. The fact that there are various more or less competitive therapeutic orientations still further complicates this manner of using selected definitions of success.[1]

Rogers pointed clearly to the need for new, less subjective evaluations of psychotherapeutic change. Dollard and Miller stressed that in order for psychotherapy to become a more exact science we need systems of ranking a number of variables, e.g., the "patient's ability to learn, degree of repression, strength of conflict, skill of therapist, strength of 'positive' habit, and relative favorableness of reality circumstances."[2] Therefore, it would seem advisable to evaluate the effectiveness of psychotherapy by a fairly diversified number of variables.

Hans Eysenck's Contributions

Hans Eysenck raised some critical questions about the "Uses and Abuses of Psychotherapy."[3] He questioned whether there is any real effect from psychotherapy. In examining the results reported by analysts and by eclectic non-analytic therapists, we find that there seems

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[1]Thomas Gordon, *et. al.*,"Developing a Program of Research in Psychotherapy," in Carl R. Rogers and Rosalind F. Dymond (eds.), *Psychotherapy and Personality Change* (Chicago: University of Chicago Press, 1954), p. 27.

[2]Dollard, *op. cit.*, pp. 427-428.

[3]Hans Eysenck, *Uses and Abuses of Psychology* (Baltimore: Penguin, 1953).

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to be a reported rate of recovery from neurosis of approximately two out of three individuals. Eysenck indicated that studies with a control group showed that of those neurotic individuals receiving no therapy better than two-thirds had recovered spontaneously in two years:

> The cases were followed up for five years or more, and often as long as ten years after the period of disability had begun. The following criteria of recovery were used: they are much more explicit and at least as stringent as those used by most psychiatrists and psychoanalysts in their work: (1) Return to work, and ability to carry on well in economic adjustments for at least a five-year period; (2) Report of no further or very slight difficulties; (3) Making of successful social adjustment. It was found, using these criteria, that 72 per cent of the patients recovered after two years. Another 10, 5, and 4 per cent, respectively, recovered during successive years, so that altogether 90 per cent recovered after five years. Taking the two-year period as the most reasonable for comparative purposes, we find again, therefore, that in this sample also, two out of three neurotics recovered without benefit of psychotherapy. . . .[4]

One could draw at least two different conclusions from Eysenck's report: either psychotherapy is not really helpful or Eysenck's study has missed some of the important variables of improvement present in those receiving psychotherapy and missing in those improving spontaneously without therapy. The first possibility drives us back to the realization that the criteria used to evaluate the success of psychotherapy are not yet as quantifiable as we need or would like. Quantifiable criteria would determine the validity of Eysenck's argument. Insofar as counselors read Eysenck and remain counselors they are working to refute Eysenck's argument. Insofar as counselors work to improve their skills and to find more effective techniques they sense the barb

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[4] *Ibid.*, p. 198.

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in Eysenck's argument.

Many psychotherapists have questioned or challenged Eysenck's conclusions. Some have even attacked Eysenck, thus giving credence to his suspicion that psychotherapists regard their work as sacrosanct.[5] However, we must also ask what Eysenck's conclusions actually indicate or prove. It must be noted that the criterion of success as release from neurotic complaints is indeed too nebulous. Furthermore there is no attempt to indicate whether the treated and the untreated neurotic individuals had the same degree or the same quality of change. In fact, analytic as well as many eclectic psychologists would contend that the improvement of the untreated group might actually be a strengthening of neurotic defenses to make the ego appear stronger. They might call it a "flight into sanity" by which individuals avoid the challenge for change inherent in most forms of psychotherapy. Furthermore, Eysenck's argument does not address our concern for the effects of situational stress in creating neurotic symptoms. Eysenck responded to such questions by contrasting the psychoanalytic view unfavorably to a learning theory orientation.[6]

Timothy Leary is yet another outstanding psychologist who has become critical of the effectiveness of the traditional forms of psychotherapy. In conjunction with F. Barron he studied the degree of change

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[5]Hans Eysenck, *The Effects of Psychotherapy* (New York: International Science Press, 1966), p. 5.

[6]*Ibid.*, p. 41.

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in neurotic patients with and without therapy.[7] About the same time Leary shifted his goal in psychotherapy from personality change to improved interpersonal relationships. He stressed the value of modifying interpersonal behavior. He conceived of all social, emotional, interpersonal activities of the individual as attempts to either avoid anxiety or to establish or maintain self-esteem.[8]

Carkhuff's and Truax' Contributions

Carkhuff refuted the myth that counseling will rehabilitate the troubled person. He stated that counseling too often provides us with inadequate models, e.g., the analyst's shadowy figure and the client-centered counselor's reflective mirror-image. When we look from the counselor to the tools of his trade we see a battery of psychological tests of questionable value. Carkhuff added the stinging conclusion that the general counselor's personality is inadequate and is the prime limiting factor in psychotherapy. He asserted that counselors are not able to allow their clients to attain more success in human relationships than they themselves have found.[9] Carkhuff maintained that the hope for effective counseling lies in the counselor's personal traits.

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[7]F. Barron and Timothy F. Leary, "Changes in Psychoneurotic Patients With and Without Psychotherapy," *Journal of Consulting Psychology*, XIX (1955), 239-245.

[8]Timothy F. Leary, *Interpersonal Diagnosis of Personality* (New York: Ronald Press, 1957), pp. 15-16.

[9]Robert R. Carkhuff and Bernard G. Berenson, *Beyond Counseling and Therapy* (New York: Holt, Rinehart and Winston, 1967), p. 13.

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He stated that a counselor can be effective if he is integrated, authentic, and non-defensive in his counseling, and if he can provide a safe and secure atmosphere by his "acceptance, unconditional positive regard, love, or non-possessive warmth for the client"[10] and if he can accurately understand the client.

The conclusion to the review of the current state of research on the effectiveness of psychotherapy is that we are able to use the criterion of success in only a qualified sense. Truax and Carkhuff pointed to the difference in recoveries as a result of psychotherapy as contrasted to no-therapy. Their research gives more credence to the use of the concept of effectiveness as it applies to psychotherapy.[11]

Carl Rogers summarized some of the difficulties in describing psychotherapeutic success. There are many definitions of success. The definitions often overlap or contradict each other. For instance, Rogers discussed four definitions of success and demonstrated that the removal of symptoms, the increase in ability to cope, social behavior and adjustment, and satisfaction with self are unacceptable as presently understood. The value that the counselor attaches to success criterion determines the importance and interpretation he gives it, thus leading to a lack of agreement among therapists on one another's success rates. A further difficulty in the evaluating of degree of

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[10]Charles B. Truax and Robert R. Carkhuff, *Toward Effective Counseling and Psychotherapy* (Chicago: Aldine, 1967), p. 1.

[11]*Ibid.*

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client improvement is that the counselor may be subtly and unconsciously training the client to gain the counselor's approval by changing in ways which the counselor regards as meaningful measures of improvement. At the present time it is difficult to determine which of many criteria are measures of improvement accepted by a wide spectrum of counselors. It may be close to impossible to note the subtle and unconscious factors influencing the client. On the basis of so many complicated and uncontrolled factors Rogers stated:

> In short, it is quite impossible at the present time to define 'success' or 'adjustment' in such a way that the definition is both operationally clear and acceptable to all. And even to the degree that there is concurrence of judgment in such a definition, it is simply a pooling of value judgments, which is a most unsatisfactory basis for a research program.[12]

II. DETERMINANTS OF EFFECTIVE PSYCHOTHERAPY

Rogers did, however, allow for the use of the criterion of success as long as it is understood as being in quotes and meaning only what is explicitly described as the standard of success chosen for a particular research. Thus Rogers is able to use the evaluations of clients and counselors to compare these subjective evaluations with more objective indices such as tests.[13] It also allows researchers to give operational definitions of success to their observations. For instance, a research project might define success as continuation in

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[12] Gordon, *op. cit.*, pp. 28-29.

[13] *Ibid.*, p. 29.

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counseling, while there might be no indication that the client is better in any objectively measurable way.

There are at least three useful determinants of psychotherapeutic effectiveness or success: insight and attitude change, behavior change, and improved scores on personality-trait and projective tests. All three of these will be considered in the research reported in this dissertation.

III. NEED FOR NEW PSYCHOTHERAPEUTIC MODALITIES

Psychotherapy as presently practiced is limited for a number of reasons. It is not available to many in need of help. It seems unable to truly help many persons, especially those of the lower socioeconomic classes. Brill and Storrow claimed that the failure of counseling to be more helpful to lower socioeconomic status individuals is due to its restriction to too few modalities, regardless of the needs of the client

> Rather than being criticized on the grounds of discrimination against the lower class individuals, we feel that many psychiatrists and psychiatric clinics are open to criticism for their tendency to restrict treatment to one modality. It may be that education will result in a more sophisticated and more psychologically minded public that will more uniformly seek psychotherapy for emotional disorders but until that time arrives, psychiatrists are obliged to employ treatment methods that are designed to help all patients and not just those which for a variety of personal reasons they prefer to use.[14]

Therapists and agencies may face a number of risks in trying to serve the socially handicapped individuals not presently receiving help.

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[14]Norman Q. Brill and Hugh A. Storrow, "Social Class and Psychiatric Treatment," in Frank Riessman, Jerome Cohen, and Arthur Pearls (eds.), *Mental Health of the Poor* (New York: Free Press, 1964), p. 74.

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Counselors risk loss of a kind of status they associate with serving persons of the higher socioeconomic classes. This handicap applies particularly to the church which has often tended to be geared to the aspirations and expectations of particular class groups, usually the middle- and upper-classes. Much of the work with the lower classes has been designated as "missionary work." Counselors risk the possibility of having to lay aside therapeutic techniques they have mastered only after great effort was expended. A third risk is that if no methods are certain to attain success the existing modalities "are likely to be vested with the function of giving a sort of magical assurance."[15]

Despite the risks involved, new modalities of psychotherapy should be implemented. Miller and Mishler suggested four ways this challenge can be met. They suggested that America needs a good five dollar psychiatrist (less expensive or subsidized counseling), therapists trained to note cultural differences, new forms of therapy for the 'difficult' client, and more therapists (non-medical counselors to handle many cases).[16]

The call to evaluate the effectiveness of counseling with clients of all socioeconomic classes is clear. If the allegation that counseling is limiting its own breadth of effectiveness is true, then new

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[15]Harry C. Bredemeier, "The Socially Handicapped and the Agencies," in *Ibid.*, p. 100.

[16]S. M. Miller and Elliot C. Mishler, "Social Class, Mental Illness, and American Psychiatry: An Expository Review," in *Ibid.*, p. 25. The authors were here commenting on the recommendations growing out of the Hollingshead and Redlich study.

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modalities must be devised and implemented.

IV. MENTAL HEALTH

The goal of counseling is to restore the mental health of the client. To the degree that this goal is not attainable counseling aspires to make as many important improvements as time allows. Mental health is, in part, the absence of mental illness. But mental health is also a positive quality comprising a number of traits which enable the individual to live and function to the fullest extent of his native ability.

Marie Jahoda's Contribution

One of the more comprehensive analyses of the mental health concepts has been made by social psychologist Marie Jahoda. Her report asserted that mental health is a trait properly applied only to individuals, not to groups or society as a whole. Of course, she acknowledged that some societies are more conducive to mental health than are others. One of the points of her summary, that is of particular interest in this dissertation, is the contention that the "standards of mentally healthy, or normal, behavior vary with time, place, culture, and expectations of the social group.[17] This study utilizes the

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[17]Marie Jahoda, *Current Concepts of Positive Mental Health* (New York: Basic, 1958), pp. x-xi; and Dollard, *op. cit.*, p. 421. The authors noted the impact of cultural conditions on the definition and the creation of emotional stress and illness.

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assumption that persons of different socioeconomic classes will have different conceptualizations of mental health, although there may be some degree of overall agreement.

Jahoda listed as unsuitable conceptualizations of positive mental health: the absence of mental disease, normality, and various states of physical and emotional well-being.[18] Jahoda did, however, find six concepts useful in describing positive mental health.

The first, attitudes of an individual toward himself, includes four subdivisions, each represented by a different school of psychology. The subgroups include: accessibility of the self to consciousness (Mayman, Allport, and Barron); correctness of the self-concept (Fromm); feelings about the self-concept (Maslow); sense of identity (Cattell's *self-sentiment*, McDougall's *sentiment of self-regard*, and Erikson's *ego-identity*).

Second, growth, development, and self-actualization (Goldstein; Fromm, Allport, Mayman, and Jung) emphasized the goal orientedness of life and health.

Third, integration has been stressed as a criterion for mental health. Integration as a criterion for mental health is treated with emphasis on one of the following aspects: (1) a balance of psychic forces in the individual, (2) a unifying outlook on life, emphasizing cognitive aspects of integration, and (3) resistance to stress.[19]

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[18] *Ibid.*, Ch. 2.

[19] *Ibid.*, p. 36.

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The first emphasis, a balance of psychic forces in the individual, represents the reformulation of orthodox Freudian analysis by the ego-psychologists like Hartmann, Dris, and Kubie. The second emphasis, a unifying outlook on life, is represented by Allport, who spoke of the individual's *unifying philosophy* which grows out of the synthesis of *self-extension* and *self-objectification.*[20] The third emphasis, resistance to stress, is particularly relevant to this dissertation's assumption that stress exerts disproportionate strain on persons of lower socioeconomic classes. Health is thus defined not as the absence of stress, but as the ability to face, cope with, and bounce back from stress. Jahoda claimed that the absence of anxiety could not be utilized as a criterion of mental health. Anxiety is a universal experience. She assumed that the individual's ability to cope with his anxiety is a more reliable criterion of mental health than is the amount of stress actually incurred by the individual. She noted that Paul Tillich thought of self-affirmation and courage as the appropriate ways of dealing with one's anxiety.

Fourth, autonomy has been regarded as a criterion for mental health. The first emphasis of this mental health criterion is the regulation of behavior from within. The second emphasis of autonomy as a criterion of mental health is as independent behavior. The concept of autonomy is in conflict between three aspects: ". . . how decisions are

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[20] *Ibid.*, p. 39; and Arthur Kornhauser, "Toward an Assessment of the Mental Health of Factory Workers," in Riessman, *op. cit.*, p. 55.

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made and what consequences they have in behavior but also the context and aim of the decision."[21]

Fifth, perception of reality has been stressed as a criterion of mental health under two emphases: perception free from need-distortion, and empathy or social sensitivity. These emphases would probably be indicated on the T-JTA Profile by a high objective and a high sympathetic score. Jahoda (1950), Maslow (1954), and Barron (1955) are representatives of this approach. Foote and Cottress (1955) emphasized the aspect of empathy.

Sixth, and finally, environmental mastery has been stressed as a criterion for mental health. Jahoda treated six aspects of the environmental mastery criterion ranging from the most to the least specific forms of human functioning. All are based on the twin themes of success and adaptation. The first emphasis, the ability to love, has been stressed by Hacker (1945) and Erikson (1950). Both emphasized genitality as one of the chief indications of a healthy personality. Many clients in individual and marital counseling refer to their frustration in sexual relationships. Second, environmental mastery as adequacy in love, work, and play is stressed by Ginsburg (1955), Mayman (1955), and Blau (1954). Short term counseling often regards improved mastery of love, work and play as an important criterion of improvement. Many of the clients complain of their failure and pain in these areas. Third, adequacy in interpersonal relations, based on the theories of

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[21] *Ibid.*, p. 48.

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Sullivan, Horney, and other neo-Freudians, is stressed as a criterion for mental health. Many clients disclose both their loneliness and their fear of becoming involved with others. Modern society often lacks opportunities for individuals to experience real community. In a society filled with stress, clients have an extra burden in the task of establishing and maintaining satisfying interpersonal relationships. Fourth, meeting of situational requirements as an emphasis on environmental mastery has been stressed by Fillmore Sanford (1956) and Julius Wishnes (1955). They attempt to specify situational requirements which can be utilized as a criterion of mental health. Fifth, adaptation and adjustment implies as a criterion of mental health the ability of the individual and society to adjust to each other. This is an assumption behind the community psychiatry approach to mental health. Sixth, problem solving is viewed as a criterion of mental health. The problem solving criterion can be placed on either the success of or on the process of problem solving.

Jahoda's summary of the multiple criteria of mental health points to the need to use multiple criteria, measured both objectively and subjectively, to adequately define and measure mental health. The discussion of mental health found in Jahoda's work has helped both in deriving conceptual definitions of mental health and in the need to choose a few measurable criteria in order to define mental health operationally for this research.

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T-JTA and Mental Health

This study will utilize the Taylor-Johnson Temperament Analysis test's ideal profile as one attempt to establish a relatively objective standard of mental health. The T-JTA test was designed to indicate the normal range of individual personality trait differences. It was not designed to be of use in the diagnosis of the various psychotic states. However, the shading of the Profile Sheet is designed to indicate whether the client has a good rating on each of the nine personality traits.

> The shaded zones of the Profile Sheet are intended to serve as a guide to the evaluation of the plotted scores. They do not, however, represent specific, statistically determined areas. The shaded zones represent the consensus of clinical judgment and experience of a group of psychologists who have used the original JTA for many years, and who, for the past three years, have worked with the T-JTA in their classes and in private practice. Experimental T-JTA results were compared with clinical impressions and with other test findings. The results of these studies and observations indicated that individuals who score in the area which has been shaded darkest have the best adjustment in interpersonal relationships, while those scoring in the white area have the most serious problems. Between the two extremes can be found varying degrees of the traits involved.
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> A clinical value for each of the four shaded zones is given at the bottom of the Profile: *Excellent, Acceptable, Improvement desirable, Improvement urgent.* As the shade of each area becomes progressively lighter, poorer and poorer adjustment is indicated.[22]

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[22]Robert Taylor, *Taylor-Johnson Temperament Analysis Manual* (Los Angeles: Psychological Publications, 1967), pp. 1-2. The Manual offered a further description of the process by which the ideal shaded area was determined: "*The shaded zones* on the Profile Sheet were based on the clinical judgment of well-trained professional psychologists and counselors, long experienced in the use of both the JTA and the experimental forms of the T-JTA. After these shaded zones were established by clinical judgment, a study was made of the distribution of scores in each area. Subgroups of both Student and General Population samples were analyzed individually and the 1964 profile shadows adjusted accord-

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Although the shaded zones of the Profile Sheet are a sampling of counselors' subjective opinions of the ideal personality traits, it seems reasonable to assume that the person whose traits closely approximate the dark shading of the Profile Sheet will be mentally healthy on Jahoda's first criterion, the attitude of the client toward his own self.

Mental Health as Understood in this Dissertation

The definition of mental health proposed in this study is based on the multiple criteria of the ability to face and cope with life, and the attitudes the individual has toward himself. It is assumed that these criteria are interdependent. As the individual is able to function better he will have higher self-regard. As his self-regard is enhanced he will become freed from self-defeating characteristics born out of low self-esteem. In short, better actions will lead to better feelings, and vice versa.

Three indicators of mental health are used in this research: the client's Semantic Differential scores, the client's and counselor's estimate of improvement, and the client's T-JTA scores. The client's

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ingly on the 1966 and 1967 editions.

Further support for the placement of the shaded zones was provided by Prof. W. Lee Morrison's study involving the conception of an ideal teacher as projected by experienced supervisors, who answered the T-JTA questions as they felt a so-called 'Ideal Teacher' would respond. The composite scores produced a Profile in which all traits fell within either the Excellent (7 traits) or the Acceptable (2 traits) shaded areas, as reported in the Validity section of the Manual."

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degree of mental health is estimated from his rating of the Semantic Differential test's adjectives. Mental health is understood as choices toward the positively scored adjectives. This is, of course, open to the criticism of relating mental health to freedom from the problems (perhaps transient) and the consequent stress which reduce the positive evaluation a client might give himself. However, in many cases the problem is permanent rather than transient, deep seated rather than superficial. Therefore, the Semantic Differential score was assumed to be a useful indicator of mental health. The client and the counselor each rated the client on the adjectives in the Semantic Differential instrument. The degree of change from the client's first to his second test was tabulated on the computer cards and the results are contained in the chapter on results. The results also noted the comparison of the client's score on the T-JTA and on the Semantic Differential intended to test for the same personality trait.

The client's T-JTA tests were graded for the number of percentage points of improvement or deterioration, i.e., the change toward the dark shaded zone on each of the nine personality traits. The scores were marked plus or minus depending on whether the change was in the direction of improvement on the T-JTA Profile. The Attitude Scale and the number of MID's were also noted on the computer cards and were tabulated in the results.

This research project does not presume to diagnose psychiatric categories of mental illness. Rather, it investigates the problems which exert debilitating stress upon individuals. Therefore, a

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functional concept of mental health was deemed adequate for the research.

Mental Illness and Life Stress

Although this dissertation will not utilize psychiatric diagnoses of mental illness,[23] it will note the degrees of impairment seen in mental disorders, or strain, as Langner described it from the community psychiatry standpoint.[24] Langner compiled a record of the stresses experienced. From this list he calculated a mental health statistic, or ridit.[25] The Mental Health Rating I excluded all reference to the respondent's sociocultural functioning. It utilized "psychiatric symptoms and mental and emotional attitudes to society and health."[26] Age

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[23]See, for instance, the classifications in American Psychiatric Association, *Diagnostic and Statistical Manual on Mental Disorders* (Washington: 1952).

[24]Thomas Langner and Stanley T. Michael, *Life Stress and Mental Health* (Glencoe: Free Press, 1963), p. 1; and Jerome K. Myers and Bertram Roberts, *Family and Class Dynamics in Mental Illness* (New York: Wiley, 1959), p. 15. Myers and Roberts used Henry Murray's conception of external press creating internal stresses: ". . . stress is 'an unpleasant emotional tension' engendered in an individual when he feels that he is unable to satisfy his needs within his situation of action. If the individual is unable to resolve the problem, his state of tension tends to manifest itself in behavior that reflects anxiety and/or hostility laden with guilt about an immediate or anticipated loss of gratification. . . . Emotional stress involves sensitivity to internal threats, fears, guilts, and conflicts. In the framework of press-stress, functional mental illness may be viewed as an individual's adjustment to social press and emotional stresses."

[25]Myers, *op. cit.*, p. 5; and Langner, *op. cit.*, p. 113 n. "The term 'ridit' derives from the phrase '*R*elative to an *I*dentified *D*istribution.'"

[26]Langner, *op. cit.*, p. 50.

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and marital status were also used to determine the rating. A Mental Health Rating II, which included the effect of the respondent's socio-cultural functioning, differed from the first rating in approximately 25 per cent of the cases. Both ratings estimated the severity of the psychiatric symptoms and their affects on the person's ability to function. A seven step gradation was employed.[27]

The seven grades of impairment were collapsed into four categories: well, mild impairment, moderate impairment, and impaired. Most of the clients coming to the Family Service Association of Pomona would probably be rated well or mildly impaired.

In evaluating the population sample Langner assigned the respondents to six gross diagnostic types. The seven steps of impairment were applied to each of these diagnostic types: namely, probable organic type, probable psychotic type, probable neurotic type, probable psychosomatic type, probable transient-situational personality reaction type, and probable personality trait type.[28] Langner's fifth type, probable transient-situational personality reaction type, assumed that some individuals might use psychiatric symptoms temporarily in adjusting

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[27] *Ibid.*, p. 52. The seven step gradation was:

0 No evidence of symptom formation (symptom free)
1 Mild symptom formation but functioning adequately
2 Moderate symptom formation with no apparent interference with life adjustment
3 Moderate symptom formation with some interference in life adjustment
4 Serious symptom formation, yet functioning with *some* difficulty
5 Serious symptom formation, yet functioning with *great* difficulty
6 Seriously incapacitated, unable to function

[28] *Ibid.*, pp. 53-56.

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to an overwhelming emotional impact. The expectation that clients' T-JTA Profile will improve as the situation improves is based on the theory that many of the clients are of this type. However, Langner found an insignificant number in this group and he later removed it by reassigning the individuals, primarily to the Probable Neurotic Type.[29] Langner also noted the symptom group to which each respondent belonged.[30]

Langner studied the ridit of fourteen factors to determine the statistical chances of mental health impairment following that particular stress. Each of the factors was scored as having a certain value or strength, depending on whether the stress had occurred 'often,' 'sometimes,' or 'rarely or never.' The ridit for the frequency of Parents' Quarrels had risks of .58, .51, and .48 respectively. The higher ridit was related to a worse mental health risk. "For example, persons reporting Childhood Economic Deprivation had a risk of .57. Thus 57 per cent of the population is healthier than the average person reporting economic deprivation in childhood."[31] Socioeconomic status appeared to be the most important demographic factor related to mental

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[29] *Ibid.*, p. 56.

[30] *Ibid.*, p. 58. The symptoms listed were: Epileptic, Intellectually retarded, Structural Brain disease and/or senility, Alcoholic-probable alcoholic, Behavioral problem-dyssocial, Mixed anxiety, Anxiety--free floating, Anxiety--phobias, Obsessive-compulsive trends, Somatic preoccupied--hypochondriasis, Neurasthenia, Passive-dependent personality, Depression, Rigid personality, Schizoid personality-withdrawn, Aggressive Personality, Suspicious, Hostile Personality, Schizophrenic, Cycloid-affective psychosis, None of the Above Symptoms.

[31] *Ibid.*, p. 149.

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health risk. Langner noted the significance of the relation of mental illness and social class.[32]

Two hypotheses are offered for the disproportionate impairment suffered by low socioeconomic status persons experiencing approximately the same amount of stress as higher socioeconomic status persons.

> Several hypotheses can be invoked to explain why the low SES risks are larger, even when the number of factors is controlled. Suppose we liken the environmental stresses to hammer blows. The low status group may have *poor resistance* to the stress of the blow, less ego strength, or weaker average personality structure. A corollary hypothesis is that the high status group has a more *resilient personality*.
>
> A blow on the high SES, although of equal force originally, may also be *cushioned* by various advantages that accrue to this stratum.
>
> In addition, *the meaning and interpretation of the factors* may vary among the socioeconomic groups. For instance, what the low status person reports as good health the high status person may report as poor health, for we tend to compare or refer our health to friends of similar age, sex, religion, and social class.[33]

Kornhauser found a similar result in his study of the mental health of Detroit factory workers:

> In sum, then, the indications from our present data are: a) that mental health (as here assessed) is poorer among factory workers as we move from more skilled, responsible, varied types of work to jobs lower in these respects, and b) that the relationship is not due in any large degree to differences of pre-job background or personality of the men who enter and remain in the

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[32] *Ibid.*, p. 151. Langner stated: "It might appear that the stress factors had 'explained away' the differences in the mental health of the three SES groups, and that our troubles were over. When we removed most of the stresses, the SES groups seemed to have identical mental health. However, quite the opposite was true. With the exception of the group that experienced none of the factors, those of low status consistently exhibited greater mental health risk, regardless of the number of factors they experienced(p. 152)."

[33] *Ibid.*, p. 1.

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> several types of work. The relationship of mental health to occupation, in other words, appears to be 'genuine'; mental health is dependent on factors associated with the job.[34]

Lower socioeconomic status individuals generally have the less skilled factory jobs. The job itself may be one of the determining factors for the disproportionate impairment from the stress among lower socioeconomic status individuals.[35] Of course the counselor also needs to assess the obverse of this proposed relationship, i.e., the degree to which prior psychological stress or impairment reduced the level of employment the individual could attain.

V. EFFECTIVE PSYCHOTHERAPY

Researchers of psychotherapy themselves enter a maze when they search for a widely acceptable definition of effective psychotherapy. Therapists of each of the many and divergent orientations: Freudians, Rogerians, behaviorists, etc., tend to evaluate therapy as effective only if it approximates the process and goals of their own theoretical orientation. Psychotherapists would be more objective about their own work if counselors were informed by and guided by, but not limited by, their own theoretical orientation. The effectiveness of psychotherapy is hindered by the fraudulent concept that the client must meet the counselor's requirements if counseling is to proceed. Not enough emphasis has been given to the possibilities of mutual compromises of

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[34] Kornhauser, *op. cit.*, p. 55.

[35] *Ibid.*, pp. 55-56.

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style, leading to an interaction which is therapeutic.

Client's Criteria of Effectiveness

The Joint Commission on Mental Health noted that many persons seeking counseling are in fact not ready to accept their own responsibility for their problem. Many persons seeking counseling in fact want support for the ideas and positions they now hold. The Commission concluded that because many are not willing to accept responsibility for their problems and are not ready to seek personal changes they shy away from depth psychotherapy and instead seek support from a clergyman or physician. It is interesting in light of the orientation toward supportive and short term counseling at Family Service Agencies to find in the Joint Commission's report that a higher percentage of persons seeking help from physicians and clergymen reported they had been helped than those who went to a psychiatrist.[36]

Since many persons can seek help from their physician or clergyman the field of psychotherapy would probably benefit from the development of a technique by which to accept the client's original statement of the problem and then lead him to deal with his own responsibility regarding it. Therapy has often been less than effective because of the client's inability to meet the counselor's conditions of treatment. The therapists' conditions of high fees, coming to the counselor's office

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[36]Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York: Basic, 1961), p. 103.

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at an hour convenient to the counselor, the need for protracted counseling, etc., may be more for the counselor's benefit than for the client's welfare. However, lower- and working-class persons have the same problems as their more affluent neighbors and counseling should be available to them. Earlier research has pointed to a gap between the counselor and the lower socioeconomic class client which inhibits communication and thereby reduces the possibility of offering effective counseling. Some therapists regard communication as the very essence of counseling. But clinical observations have indicated the difference in individual's ability to communicate. Some persons are able to trust others and to communicate with them. But there are some who have been taught from childhood to feel guilty about any feelings, and who therefore block any communication.[37] The counselor has the opportunity to evaluate the content and the process of the client's communication. He must also make a judgment of what communication to the client would be helpful.[38] It is sad and ironic that the mental health professions, which ostensibly intend to help persons improve their ability to communicate, have in fact not been open for two-way communication. Attempts at one-way communication are seen by those social welfare agencies which label and condemn some families as multi-problem families. The agencies assigned the task of helping the lower socioeconomic class

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[37]Carroll Alonzo Wise, *Pastoral Counseling* (New York: Harper & Row, 1951), p. 6.

[38]*Ibid.*, p. 7.

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families are unwilling to face their failures to be of help and instead of trying to communicate with the multi-problem families, the agencies tend to dismiss them as pathological and hopelessly dependent upon the welfare agencies.[39]

If the social welfare agencies could muster the courage to look at themselves objectively and to communicate openly with those they seek to help, a new model of the agency might be forthcoming. One such model would be that of advocate for the client. The client often wants to know that he has someone on his side. This could be one of the beginning stages of primary prevention (i.e., reform the conditions responsible for mental illness) rather than secondary prevention (i.e., early diagnosis and treatment of individuals and families suffering under life stress). Although primary prevention is extremely important the emphasis in this dissertation is on secondary prevention (because that is the area in which counseling is conducted). The field of psychotherapy is consequently required to objectively evaluate if it should continue to exist. If it refuses to or fails in refuting the contention that psychotherapy produces no real change then it no longer deserves to consider itself a scientific discipline.

Because of the stress placed on the effects of psychotherapy we must examine the factors which may produce more effective counseling. The role of the therapist is one of the most important factors in

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[39]Francis P. Purcell, "The Helping Professions and the Problems of the Brief Contact in Low Income Areas," in Riessman, *op. cit.*, p. 437.

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counseling. The classical analytic role for the therapist is to remain quiet and somewhat mysterious. Psychoanalysis was based on the assumption that the patient would identify the analyst with a libidinized person in his life and then that he would work out his problem through the transference neurosis. This process relied heavily on free association and the patient's agreement to say whatever came to his conscious mind. The Rogerian approach would also refuse to identify the counselor too specifically. Regardless of the Rogerian counselor's personal opinions he is disciplined to reflect the client's feelings back to him. Casework oriented counselors and directive therapists might not be oblivious to the client's feelings, but they are quite specific in educating the client to the opinions and life styles they believe will improve the client's quality of life.

The factor of authority is another important factor in counseling. Regardless of his theoretical orientation the counselor asserts his authority by being in control of the ways he will work with and relate to the client.[40]

Other important factors in effective counseling include the training, age, and personal traits of the counselor. When more complete objective studies of the effectiveness of counseling are available we will be able to note which counselors tend to be more productive of positive changes in the client. Therefore, we must adopt criteria of effectiveness for the research reported in this dissertation.

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[40]Jay Haley, *Strategies of Psychotherapy* (New York: Grune & Stratton, 1953).

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Criteria of Psychotherapeutic Effectiveness

The first criterion of effective therapy will be the amount of change on the follow-up T-JTA scores and the change on the follow-up semantic differential ratings. The second T-JTA tests for each client were scored for the number of percentage points by which they improved on the first test in approximating the dark-shaded (excellent) area of the T-JTA Profile Sheet. A change score was noted for each of the nine traits plus the change on the attitude scale. Of course, it was understood that there could be either positive or negative changes or identical scores on both tests, in which case there would be no change. If the score for any trait was in the excellent area on the first test and again on the second test a score change of zero was assigned because the change that occurred was within the excellent range. It was assumed that the change had the same significance and importance regardless of where the two scores were in terms of the ideals designated on the T-JTA Profile Sheet. Thus the same ten point improvement score was given for the client whose score on trait A (Nervous) improved from 99 to 89 and for the apparently composed client whose score improved from 40 to 30. The same procedure was followed in scoring the client's two scorings of the semantic differential instrument. On each of the 24 traits a positive side was established. The client indicated where he rated himself by making a mark intersecting the three and a half inch line drawn between the contrasting adjectives. In scoring the tests a value of one was given for each half inch distance from the left end of the line to the mark. In comparing the initial and the follow-up scores a plus

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value was assigned as the follow-up score approached the trait designated as more indicative of positive mental health. The degree of change, positive or negative, of each of the pairs of scores from the T-JTA and the semantic differential instrument were then punched on IBM computer cards for tabulation. Further card punches were used to indicate the subjective rating of improvement given by both the client and by the counselor. Thus the evaluation of the client's improvement could be made on the basis of the nine traits and the attitude scale on the T-JTA, the twenty-four adjective pairs of the semantic differential instrument, and the client and the counselor evaluation of improvement. These results were used to evaluate what effects the counseling examined had. The effectiveness was evaluated as a variable of socioeconomic status and of goal congruence, both of which will be defined as they were utilized in this research.

This chapter has attempted to explore and discuss the material on the effectiveness of psychotherapy. The charge that clients in counseling in general improve no more than persons receiving no counseling was discussed and challenged. In general the effectiveness of counseling can be evaluated on the bases of three determinants: insight and attitude change, behavior change, and improved scores on personality trait and projective tests. The research in this dissertation employed all three criteria to evaluate effectiveness. The tentative conclusion is offered that psychotherapy has tended to limit itself to too few modalities and that, therefore, the psychotherapeutic discipline needs to devise and implement further counseling modalities. With this

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conclusion the description of the variables is complete and the following chapter describes the research on which this dissertation is based.

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CHAPTER V

PURPOSE AND PROCEDURE

The purpose of this study was to measure the effectiveness of counseling with clients of different socioeconomic classes and with different degrees of client-counselor goal congruence. The study evaluated the changes in clients after five interviews at the Family Service Association of Pomona. The measures of effectiveness included: (1) the changes on the Profile Sheet of the Taylor-Johnson Temperament Analysis (T-JTA) test, (2) the changes on a semantic differential instrument, (3) the client's continuing to come for at least five sessions, and (4) the client's and the counselor's subjective evaluations of the help received. The effectiveness was considered as a function of the socioeconomic status of the client and of client-counselor goal congruence.

I. MEASUREMENT OF CHANGE

A number of methods were used to measure the change in the client's feelings and attitudes. The need for multiple measures was dictated by the facts that only small changes could be anticipated after five counseling sessions, that the changes could be elusive, and that there are numerous criteria of change.

Taylor-Johnson Temperament Analysis Test (T-JTA)

The first instrument used to evaluate the changes in the client

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was the T-JTA test which was administered immediately after the first and immediately after the fifth interviews. Both scores were marked on the same Profile Sheet to facilitate the measurement of change.

The T-JTA is a revision and standardization of the instrument developed and published by Roswell H. Johnson in 1941. The original test was designed for use in cases of individual, pre-marital, and marital counseling. Robert M. Taylor and Lucille P. Morrison revised the instrument in an improved statistical form in 1964. The Test Manual stated the purpose of the instrument:

> This test is intended to serve as a quick and convenient method of measuring a number of important and comparatively independent personality variables or behavioral tendencies. . . . *The test is designed primarily to provide an evaluation in visual form showing a person's feelings about himself at the time when he answered the questions.* The T-JTA also makes possible the early identification of emotionally troubled individuals, so that assistance may be provided before serious disruption of relationships occurs, or before emotional states become acute.
>
> While this test was not designed to measure serious abnormalities or disturbances, it does provide indications of extreme patterns which require immediate improvement. In general, however, the T-JTA is designed for use in the more usual counseling situations, such as student and vocational guidance, pre-marital, pastoral, and individual counseling.[1]

The T-JTA has been used over the last year to test most clients at the Family Service Association of Pomona. The instrument has been useful in locating areas of difficulty and enabling both the client and the counselor to conceptualize the difficulty against the norms of a general population published in the T-JTA Manual. The T-JTA does not pretend to find the areas of psychopathology indicated on tests like the

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[1]Robert M. Taylor, *Taylor-Johnson Temperament Analysis Manual* (Los Angeles: Psychological Publications, 1967), p. 1.

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Minnesota Multiphasic Personality Inventory (MMPI), the Thematic Apperception Test (TAT), or the Rorschach Test. Although the MMPI and other tests serve an important function in depth psychotherapy, their usefulness in a Family Service Association is limited because most individuals come for help with an immediate problem. Usually they neither need nor wish to undertake long-range therapy. In the short-term counseling requested and offered one would anticipate very minimal changes in these more sophisticated instruments.

Limitations of the T-JTA Test. The T-JTA has certain limitations. (1) It appears to define the optimum score by middle-class norms. (2) The questions asked are not subtle, so a person could easily give all the "socially desirable" answers, rather than answers indicating his own feelings.[2] (3) On the other hand an individual with self-deprecating attitude while taking the test could give all the "undesirable" answers. (4) Finally, there has been a great deal of criticism of the statistical norms, and of the validity and reliability of the original JTA. The revision by Taylor has improved the statistical basis of the test. Research has shown the validity of an important scale on the test.[3]

The revised T-JTA was evaluated with a Factor Analysis. The

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[2] *Ibid.* For example, question #144, "Is . . . logical in thinking and speaking?"

[3] Clinton Phillips, "A Validation Study of the Attitude Scale on the T-JTA," in *Ibid.*, Supplement No. 2.

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results indicated that the T-JTA has a "strong scale measuring Anxiety and a scale measuring Introversion and Extroversion."[4]

The T-JTA utilizes a question booklet with 180 statements which the client is asked to apply to himself and indicate whether they describe him by marking the column indicating agreement, disagreement, or uncertainty. The instruction page encourages the individual to make his answer agreement or disagreement whenever possible, thus avoiding the "MID" answers.

The test utilizes twenty questions on each of the nine scales to ascertain the individual's rating on the norms of nine personality traits for a general population. The ratings are based on separate norms: for adult men and women, for college men and women, and one norm for Criss-Cross, i.e., when a person scores a test the way he believes another person, usually his spouse, would score it.

T-JTA Norms. The norms of the instrument are based on the tests administered to 925 persons in a general population, 1,607 in the college population, and 326 in the Criss-Cross population.[5]

The T-JTA Manual further described the population sample by occupation, student or non-student status, and marital status. During the period when research was done on the instrument 370 different occupations were indicated on the answer sheet. Thirty-three per cent were in Business and Finance, 21% were in Science, Engineering, and

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[4]Taylor, *op. cit.*, pp. 35-36.

[5]*Ibid.*, p. 23.

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Construction, 10% were skilled, semi-skilled, and unskilled public services, 8% were Medical, Dental, Mental Health, and Social Service, 6% in Church and Missionary activities, 5% in Legal activities and 2% in the Armed Services.[6] The sample appears to be heavily loaded on the side of higher socioeconomic status technical occupations. The Manual rated 16 jobs as semi-skilled, e.g., machine operation, factory worker, assembler, and maintenance man.[7] When the semi-skilled services, clerks, and skilled technicians are totaled we find that the sample contained 101 working class occupations in a total of 370 occupations. The number of higher class occupations appears higher than one would anticipate in the general population, although it is not possible to tell how many individuals are represented in each of the 370 occupations. This information is vital in determining the population sample's breadth of representation.

The validity of the T-JTA has been tested by a number of techniques. The first compared the counselor's evaluation of the client on each of the nine traits with the actual test scores. Significant positive correlations were found when using the Criss-Cross test results (i.e., comparing 'self-rated' and 'other-rated' test results).[8] The T-JTA has been subjected to testing to determine its reliability--under the headings of stability, consistency, and standard error of measurement.[9] Finally, the construct validity of the T-JTA was measured by

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[6] *Ibid.*, p. 37.

[7] *Ibid.*, p. 38.

[8] *Ibid.*

[9] *Ibid.*, pp. 16-17.

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computing its correlation with the Edwards Personal Preference Schedule (EPPS) and the MMPI.[10] For the purposes of the research reported in this dissertation, the relatively high reliability of the T-JTA should be a very desirable characteristic of the test.

T-JTA Personality Traits. The nine personality traits tested by the T-JTA provided the important variables for the research. The traits were selected to suit the aspects of the client's personality which would be of concern during counseling. By the term 'trait' the T-JTA indicated behavioral patterns and tendencies cohesive enough to be measured as a unit. The traits selected represent attitudes and feelings important in personal adjustment and interpersonal development. With most of the nine pairs of traits one is assumed to be more socially desirable, e.g., 'Composed' is preferred to 'Nervous.'

Trait A--Nervous (vs. Composed). "*Nervous* is here defined as a state or condition frequently characterized by a tense, high-strung, or apprehensive attitude. Its opposite, *Composed,* is characterized by a calm, relaxed, and tranquil outlook on life."[11] The high nervous score indicates anxiety and may be reduced with the reduction of stress or by effective therapeutic intervention.

Trait B--Depressive (vs. Lighthearted). "*Depressive* is here defined as being pessimistic, discouraged, or dejected in feeling-tone or manner. Its opposite, *Lighthearted,* is characterized by a happy,

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[10] *Ibid.*, p. 20.

[11] *Ibid.*, p. 4.

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cheerful, and optimistic attitude or disposition."[12] High nervous and high depressive are often seen in persons seeking counseling.

Trait C--Active-Social (vs. Quiet). "*Active-Social* is here defined as being energetic, enthusiastic, and socially involved. Its opposite, *Quiet*, is characterized by socially inactive, lethargic, and withdrawn attitudes."[13] The high Quiet person is either introverted or temporarily avoiding social contact.

Trait D--Expressive-Responsive (vs. Inhibited). "*Expressive* is here defined as being spontaneous, affectionate, demonstrative. Its opposite, *Inhibited*, is portrayed by restrained, unresponsive, or repressed behavior."[14] The high Inhibited score indicates the inability or unwillingness to express true feelings. With successful counseling, scores might improve as the client felt more confident in acknowledging and expressing feelings.

Trait E--Sympathetic (vs. Indifferent). "*Sympathetic* is here defined as being kind, understanding, and compassionate. Its opposite, *Indifferent*, is characterized by unsympathetic, insensitive, and unfeeling attitudes."[15] Unless carried to extremes the individual with a high Sympathetic score probably will have better interpersonal relationships than the person scoring lower.

Trait F--Subjective (vs. Objective). "*Subjective* is here defined as being emotional, illogical, self-absorbed. Its opposite, *Objective*,

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[12] *Ibid.*

[13] *Ibid.*

[14] *Ibid.*, p. 5.

[15] *Ibid.*

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is defined as being fair-minded, reasonable, and logical in attitude."[16] High subjective scores may indicate serious emotional disturbance, preoccupation with self, and decreased ability to act and think logically. On the other hand, extreme objective scores may indicate a decreased level of emotion, denial of feelings, and social distance. Thus both extremes of the Subjective trait limit an individual. Unlike most of the traits, the optimum score is not either extreme, but a balance weighted toward the objective side.

Trait G--Dominant (vs. Submissive). "*Dominant* is here defined as confident, assertive, and competitive. Its opposite, *Submissive*, is defined as passive, compliant, dependent."[17] The Dominant trait is indicative of ego-strength.

Trait H--Hostile (vs. Tolerant). "*Hostile* is here defined as being critical, argumentative, punitive. Its opposite, *Tolerant*, is defined as being accepting, patient, and humane in attitude."[18] A decrease in the Hostile score would probably indicate an increased acceptance of others and one's self. This would be particularly helpful in marital and parent-child counseling.

Trait I--Self-Disciplined (vs. Impulsive). "*Self-disciplined* is here defined as being controlled, methodical, persevering. Its opposite, *Impulsive*, is defined as being uncontrolled, disorganized, changeable."[19] High scores on self-disciplined indicate a high degree of emotional

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[16] *Ibid.*

[17] *Ibid.*, p. 6.

[18] *Ibid.*

[19] *Ibid.*

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maturity which controls impulsiveness and augurs well for gaining important future goals. The definition of maturity implied here seems middle-class and would give a poor score to a lower socioeconomic status person who has learned that immediate gratification is common sense, not immaturity.

This criticism of the apparently middle-class definition of the self-disciplined trait might be applicable to some of the other trait definitions. One would have to know further the middle-class bias in the trait definitions and the middle-class predominance in the general population samples.

The T-JTA has two further indicators of personality characteristics. They are the attitude scale and the evaluation based on the number of MIDs used. The attitude scale, a measure of test-taking bias, is similar to the K scale on the MMPI, a scale measuring defensiveness. The Attitude Scale goes from 1 to 10, with scores of 4 to 7 comprising the neutral range. Scores above or below the neutral range warn the counselor to note the effect of the client's bias in either depreciating himself or in giving himself 'the benefit of the doubt' to improve his scores. The Attitude Scale is also a measure of ego strength. Low scores point to the possibility of a weak ego, while scores of 8 to 10 may indicate a rigid ego structure.

The Manual indicated that the mean for total MID scores in the original sample was 14. More than 30 MID responses on a test has clinical significance. Very high MID scores have been found to be associated with anxiety, lack of ego-strength, or low self-

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mastery.[20]

The counselor is also instructed to note the meaning of groups of personality traits on the T-JTA. The Manual noted four Trait Patterns:

1. The Anxiety Pattern is indicated by high scores in Nervous, Depressive, Subjective, and Hostile.
2. The Withdrawal Pattern is indicated by low scores in Active-Social, Expressive-Responsive, Dominant, and possibly Sympathetic. The Subjective score is high.
3. The Hostile-Dominant Pattern is indicated by high scores in Dominant, Hostile, and Subjective along with a low score in Sympathetic. This pattern alienates others and leads to poor interpersonal relationships.
4. The Emotionally Inhibited Pattern is indicated by low scores in Sympathetic and Expressive-Responsive along with a high score in Hostile.[21]

The T-JTA has become a useful instrument for counseling, and research has been effective in establishing higher levels of reliability and validity than those of the earlier JTA. However, for the purposes of research it was thought advisable to rely on more than one determinant change. Therefore Charles E. Osgood's Semantic Differential test was used to corroborate the findings of the T-JTA.

Semantic Differential Instrument

The Semantic Differential is a method of testing described in *The Measurement of Meaning.*[22] The test asks an individual to check a

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[20] *Ibid.*, p. 9.

[21] *Ibid.*, pp. 7-8.

[22] Charles E. Osgood, George J. Suci, and Percy H. Tannenbaum, *The Measurement of Meaning* (Urbana: University of Illinois Press, 1967).

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continuum between bi-polar adjectives to best describe his feelings, attitudes, beliefs, etc. Osgood sought a series of descriptive scales defined by bi-polar adjectives to comprise a representative sample. The matrix of correlations of this testing procedure was subjected to a factor analysis, using Thurstone's Centroid Factor Method.[23]

In constructing a semantic differential for this research on counseling it was important to remember that the semantic differential is not a test proper but a technique of measurement.[24] Osgood advised that the investigator, in constructing a semantic differential instrument, use 'good judgment.'[25] If the investigator successfully uses 'good judgment' in constructing his semantic differential instrument it will be useful in research. Osgood evaluated the semantic differential on the criteria of objectivity, reliability, validity, sensitivity, comparability, and utility.[26] The semantic differential was used to measure a number of variables, e.g., attitudes, political opinions, and feelings. A number of research findings were reported relating scale-checking style to intelligence, mental disorder, response conflict, and anxiety.[27] Of particular interest for this research is Osgood's claim for the utility of the semantic differential in quantifying subjective testing instruments, e.g., the TAT and Rorschach tests. Although the T-JTA gives quantified results the results are based on the client's

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[23] *Ibid.*, p. 36.

[24] *Ibid.*, pp. 76-77.

[25] *Ibid.*, pp. 77-78.

[26] *Ibid.*, pp. 125ff., Ch. IV.

[27] *Ibid.*, pp. 226-236.

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subjective evaluation of himself. Therefore, it will be of interest to compare the results of the T-JTA and the semantic differential on the same personality traits.

A semantic differential involving personality traits was used in conjunction with the T-JTA to measure the degree and the direction of personality change after short term counseling. In constructing the semantic differential instrument for this research, the words describing the T-JTA traits were selected. Each of the nine traits was mentioned twice, once with the primary description of the trait and once with one of the words suggested by the T-JTA Profile Sheet as a further description of the primary trait. Six additional items added were two adjectives for each of the three primary semantic differential categories: Evaluation (successful-unsuccessful, kind-cruel), Potency (strong-weak, serious-humorous), and Oriented-Activity (active-passive, excitable-calm).[28]

Evaluation of Change

A third measure of change utilized was a question on the follow-up test asking the counselor's and the client's evaluation of the change during counseling. The question is matched to one on the initial test asking both the counselor's and the client's expectation of change in five weeks.

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[28]For the instrument used in this research see Appendixes B (I & II) and C (I & II).

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II. CLIENT-COUNSELOR GOAL CONGRUENCE

Since the research hypothesized a positive relation between success in therapy and goal congruence, an instrument had to be devised to measure that congruence.[29] The scores on a special semantic differential of thirteen items related to goals and techniques were compared and contrasted by use of Cronbach's D Square.[30] Cronbach warned of the dangers in trying to compare individuals:

> Thinking of persons as 'similar' or 'dissimilar' is a common oversimplification. . . . If behavior is described in terms of independent dimensions, then persons who are similar in one dimension may be no more similar in some second dimension than persons who are dissimilar in the first dimension. *In other words, similarity is not a general quality. It is possible to discuss similarity only* with respect to specified dimensions (or complex characteristics). . . .[31]

The dimensions in this research were not independent. However, much of the variation was eliminated by deriving cumulative Goal Congruence scores rather than a rating for each of four goals and five techniques. A goal congruence score was arrived at by scoring the client's and counselor's pre-test indicating the degree to which they agree with each of four goals and five techniques on a seven-point scale. Two questions were asked for each of the four goals and one

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[29] For the full text of the goal congruence questionnaire, see Appendix B (III & IV).

[30] Lee J. Cronbach and Goldine C. Gleser, "Assessing Similarity Between Profiles," *Psychological Bulletin*, L (1953), 457.

[31] *Ibid.*, p. 459. The D^2 formula is: $D_{12}^2 = \sum_{\sigma=1}^{k}(xj1-xj2)$

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question for each of the five techniques. The difference between the counselor's and client's rating for each of the thirteen statements was tabulated, squared, and totaled to give a goal congruence raw score. The higher scores indicated lower goal congruence; lower scores indicated higher goal congruence.

Counseling Goals

An adaptation of the semantic differential was also employed to have the client indicate the degree to which certain goals and counseling techniques were preferred by him. The goals from which the client rated his preference were:

1. Manipulative control of another's behavior.
2. Situational improvement in work, school, home.
3. Insight leading to personality trait improvement.
4. Improved interpersonal relationships.

For the purposes of this research no evaluation of these goals was made. Each goal was considered to be valid, at least in certain cases. The words "manipulative" or "controlling" are critically evaluated by many counselors, yet there is reason to believe that in certain situations, manipulation may be an acceptable goal.[32] This may be the case because the client is in a crisis which exacerbates his personality problems. Therefore, manipulative goals could be accepted until the person was extricated from the stressful situation. The client would then be free to decide whether or not he wished to continue in counseling. He could

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[32]Jay Haley, *Strategies of Psychotherapy* (New York: Grune & Stratton, 1963), p. viii.

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also indicate what goal he would select if he chose to continue. Manipulative goals might be thought valid for a parent seeking to prevent his child from getting into trouble at school. After the troublesome behavior had been checked the parent might change goals, e.g., to seek the child's reaction to his attitudes and actions.

Situational improvement is a second limited goal suitable for short term counseling. The counselor uses case-work techniques to discover the client's problems in school, work, or home. Then counselor and client together explore, evaluate, and implement solutions. After the situation has improved the client is free to decide whether he wants to explore the intra-personal dynamics and inter-personal relations that have helped create the problem, and which might create similar problems if no further changes are made.

Insight leading to personality trait improvement is the goal of more traditional schools of psychotherapy, e.g., Freudian analysis and Rogerian client-centered therapy. These approaches assume that if the client becomes aware of the formative events of his past and gains an awareness of the dynamics of his present behavior he will have insight. Insight is presumed to facilitate improved behavior. Insight into the childish and neurotic ways of his poor behavior supposedly frees him to choose more mature and appropriate behavior. The reality therapists reverse this equation to assert that behavior which is improved is a cause of, not a derivative of, insight.

The goal of improved interpersonal relationships is based on Harry Stack Sullivan's theory of psychotherapy, which assumed that if

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a client learns how to understand the messages he receives and the responses he gives he will be better able to cope with stressful situations and resolve his problems. It was assumed that the client who indicated this goal was, to some degree, aware of his being out-of-touch with one or more of the important people in his life. This goal would be supported by those who make the now almost trite comment that there is a breakdown in communication. It would be logical to assume that persons having difficulties with their marriage partner or their child might see the presenting problem as an indication for the need of improving interpersonal relationships.

The degree to which the client and the counselor have a congruent goal was a major emphasis in this research. It was assumed that clients came to the Family Service Association because of immediate problems in their marriage or in their parental roles. Therefore, they might be more inclined to select the first two goals of counseling, i.e., to change the problem person or improve the general situation. On the other hand, it was assumed that professional counselors are readily aware of the intra-psychic and inter-personal problems behind the immediate crisis. The counselor might then hope that his clients will deal with the crisis situation in such a way as to improve their personality traits or their ability to communicate effectively. Therefore, counselors would be expected to put more emphasis on the third and fourth goals. They would hope the clients would use the crisis situation as an opportunity to deal with their own personal difficulties.

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Therapeutic Modality

As an adjunct of client-counselor goal congruence the psychotherapeutic modality preferred was taken into consideration. The client indicated the approach he would prefer to have the counselor employ. The counselor indicated the approach he believed should be offered. Both client and counselor indicated their preference by checking the degree to which they agreed or disagreed with the use of the therapeutic approaches. Five therapeutic approaches were specified:

1. Client-centered--non-directive.
2. Directive--suggestive.
3. Objective--prescriptive.
4. Personality trait improvement--expressive.
5. Relationship improvement--communicative.

One statement was formulated for each of the above therapeutic approaches. The client and the counselor indicated their degree of agreement or disagreement with the statement describing each approach.

The client-centered approach was intended to ascertain the desire for a non-directive approach, i.e., the traditional early Rogerian approach of hearing and restating the client's statement. Of course, Rogerian therapy is nowhere as passive as some critics, who emphasize only the earlier non-directive style, would have us believe. The questionnaire's statement for the client-centered approach was: "I want the counselor to listen to me and re-state my observations and feelings." It was assumed that the non-directive approach would appear pointless to many clients and that the counselors would not favor such a passive approach.

The directive approach was intended to be more of the traditional

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case-work orientation in which the counselor encourages the client to describe the problematic situation so that together they can find alternative ways to handle the problem. The statement read: "I want the counselor to ask questions and suggest how I can handle my life better." It was assumed that many clients would choose this approach. It was further assumed that the counselors would deem this approach best for the client in a Family Service setting.

The objective approach was intended to describe the traditional medical "prescriptive" approach in which the counselor diagnoses the problem and tells the client how to handle the problem. Little or no emphasis is placed on feelings. This approach was described in the statement: "I want the counselor to ignore my emotions and help me solve my problems objectively." The objective approach was distinguished from the directive approach by the degree to which the latter attempts to ignore or disregard feelings in order to be as non-subjective as possible. It was assumed that this approach would be chosen more often by clients than by the counselors. The client might focus on his desire for an objective solution for his problem. This would be congruent with those counselors who describe their approach as being objective about the subjective. Furthermore, there is reason to believe that some clients are suspicious or fearful of any emotion (their own or that of others). The phrase "ignore my emotions" would probably rule out this approach for many counselors. It may be noted that the five approaches are not mutually exclusive. The approaches tend to blend into one another. The distinctions made are often based on a degree of

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one emphasis over another emphasis. Furthermore, for the purposes of the research conducted the emphasis was placed on the overall differences in the approaches selected by the client and by the counselor rather than on an attempt to designate the client by any one particular approach.

The emotional or expressive approach was described by the statement: "I want the counselor to encourage me to express my feelings and find how I can improve some of my personal traits." This approach was intended to describe the traditional attempt to gain insight into intra-psychic dynamics and to use that insight to liberate the person to adapt his personality to more satisfying traits. It was assumed that this approach would be agreed with by counselors to a greater extent than by the clients. The counselor would tend to see the personality traits which help create the client's crises. The client would tend to see the insight approach as involving too much time and money and seemingly offering too few prospects of reward. It was further anticipated that higher socioeconomic status clients would agree with this approach more than lower socioeconomic status clients. This anticipation might appear to be a perpetuation of the prejudice against the lower classes as being impatient and unwilling to plan and work for future goals. Actually it is assumed that all socioeconomic status clients have a high degree of resistance against the agonizing involved in insight-oriented personality trait modification. Most persons, regardless of socioeconomic status, would prefer to project the problem on the "other," so on society, and seek an immediate solution. But the

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higher socioeconomic status individual is more likely than his lower socioeconomic status neighbor to have been trained to find longer term psychotherapy acceptable. It is more likely to be a status symbol for higher socioeconomic status individuals but a stigma for lower socioeconomic status individuals.

The relationship improvement approach was intended to describe the interpersonal approaches derived from or related to Sullivan's theory. The relationship approach would focus on problem communications rather than problem people. It would attempt to overcome the barriers (e.g., fear, distrust, jealousy, etc.) that were hindering communication and making the relationship more distant and less rewarding than it could be. This approach was described in the statement: "I want the counselor to help me improve my communication with a person important to me." Agreement with this statement assumed that the client felt alienated from an "important other" and that he would like to be instructed and assisted on how he can be reconciled to that person. It was assumed that this approach would be agreed with by both clients and counselors to approximately the same degree. Many clients coming to a Family Service Agency are seeking assistance for their family through either marriage or family counseling. Therefore, they might be sensitive to their desire to improve communications within the family, as they seek a more satisfying relationship in the family. No significant difference in the choice of this approach was anticipated with different socioeconomic status.

The role relationship approaches have been widely adopted by

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pastoral counselors[33] who can readily apply their theology of reconciliation to the practice of healing through reconciliation.

In retrospect we see that a further question could have been asked concerning the client's and the counselor's preference for individual, conjoint, group, or family therapy.

Presenting Problem

The Family Service agency asks the client to indicate in his own words the problems he hopes to get help for. Since the responses given by the clients vary so greatly, and since some clients prefer not to indicate their problem in writing, we asked the clients to indicate their presenting problem with a check on the questionnaire. The choices offered were:

1. Marital problem.
2. Problem with children's behavior.
3. Personal problem in school or work.
4. Problem with emotions.
5. Uncertain about problem.
6. Other (specify)_____.

These choices were selected because they include the most frequent reasons clients had given for coming to Family Service Association of Pomona for help. They also allowed the client to indicate his confusion as well as other reasons for seeking help. The Family Service Association of Pomona gave a report of the types of problems treated

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[33]Charles William Stewart, *The Minister as Marriage Counselor* (Nashville: Abingdon Press, 1961).

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during the year from March 1, 1968 to February 28, 1969.[34] Although it does not describe the presenting problems in the categories offered above it can be compared to the categories, and it may provide an indication of the types of problems to be expected.

To a degree the assigning of primary problem category is arbitrary. A client might be experiencing a number of the problems suggested. He might find it difficult to say which is primary either in terms of the pain experienced or the cause of his problems.

It was assumed, however, that the counselors would indicate "problems with own emotions" in more cases than the clients would. "Uncertain" was included to allow persons feeling confused to mark a less depreciating alternative. It was assumed that some would come for counseling because they felt tense, etc., but were unable to say precisely what was bothering them.

Information on Clients

When a person called the Family Service Association of Pomona for help the secretary set an appointment with one of the three counselors. An intake application was mailed to the individual to fill out before

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[34] Family Service Association of Pomona, *Annual Report*, 1968-1969. The types of problems listed were:

Types of Problems	Per cent	N=297
Elderly	1	
Marital	39	
Parent-Child	26	
Personal	29	
Unwed mothers	5	

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coming for the first appointment. At the completion of the first interview the counselor explained that he would like the client to take two tests "to help in the counseling process and to help the agency provide the best service possible." The client was then given the initial test and the T-JTA. The intake application and the initial tests provided most of the important data required for each client. Some of this data was particularly important in determining the socio-economic status of the client.

III. CLIENT SOCIOECONOMIC STATUS

The definition of socioeconomic status adopted for this research was based on a review of the criteria selected by a number of the leading researchers on mental health and socioeconomic status.[35] Although some studies have attempted to categorize individuals into socioeconomic classes by combining three or four factors in a weighted or unweighted manner, there is, in fact, little evidence from which to conclude that any socioeconomic status evaluation used to date has sufficient validity to be useful for our research. The research projects which have assigned socioeconomic class ratings have ignored the important factor of the individual's feeling about his place in the socioeconomic class structure. Socioeconomic class is in part a state of mind, i.e., the

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[35] August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness* (New York: Wiley, 1958); and Thomas Langner and Stanley T. Michael, *Life Stress and Mental Health* (Glencoe: Free Press, 1963).

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individual is in the class which he believes he is in and which he behaves as a member of.[36] The wealthy Beverly Hill-billy does not pretend to have a different socioeconomic class because of his newly acquired wealth. The doctor or industrialist who voluntarily accepts poverty to enter the mission field does not feel that the loss of income or expensive residence, etc. places him in a different class. A great many surveys have shown the difference in the style of life for persons at different occupational or economic levels. The style of life, as reflected in choice of reading, use of free time, patterns of child raising, etc., of each occupational and economic level does have common traits, but it is crucial to keep in mind the fact that these observations are based on common traits found in large samples rather than on the perception of individuals within a group. We must be aware of the traits generally observed in each class. At the same time we must beware of the assumption that because a person makes a certain amount of money, and works in a particular kind of occupation he will have all or even most of the traits attributed to that particular class. Counselors must simultaneously be aware of the traits commonly found in the class a person is identified with as well as of the uniqueness of the individual which is not limited to (perhaps hardly affected by) the class to which we assign him.

Since class membership is less flexible than the cumulative socioeconomic status ratings, it seemed inadvisable to adopt or assign

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[36] Richard Centers, *The Psychology of Social Classes* (Princeton: Princeton University Press, 1949).

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cumulative socioeconomic status ratings. Instead we employed a five-step gradation for each of four factors believed to be important to the client's socioeconomic status, as well as being determinative of the kinds of stress likely to impinge upon the individuals. We were particularly concerned to evaluate what, if any, differential effect in the effectiveness of counseling occurred as a variable of these socioeconomic status factors.

Next we were able to evaluate the effects of both socioeconomic status and goal congruence on counseling. Therefore, we must have a working definition of goal congruence. Goal congruence, as described in Chapter III, is an attempt to measure the degree of agreement of both counselor and client on the desired outcome (goal) and desired method of achieving the desired outcome (approach). Another evaluation of the counselor's and the client's scores was utilized to determine to what degree each goal was selected by the client and by the counselor. This shed additional light on the goals since the total goal congruence score indicated only the difference in the ratings, but not the actual placement of those ratings.

The socioeconomic status of the client was determined on the basis of four factors: Income-level, Occupation-level, Education-level, and Self-rating-level. Each of the four factors was studied independently in trying to determine what, if any, relation exists between socioeconomic status and the results of counseling.

The income-level determinant was based on the total gross income for a family of four. This rating level was based on an examination of

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the income-level of clients in the previous year of service at the Family Service Association of Pomona. The levels of income were assigned a socioeconomic status rating:

Lower-class	$ 0	--- $ 3,400
Working-class	3,400	7,400
Lower middle-class	7,400	11,400
Upper middle-class	11,400	15,400
Upper-class	15,400	and up

A number of studies that have involved socioeconomic status have mentioned income-level as a determinant, but the rapid inflation in the last decades makes it difficult to ascertain appropriate income brackets for each class in 1969.[37]

A second factor used in ascribing a socioeconomic status rating was the occupation-level of the head of the household. On the basis of research done on socioeconomic status and mental health the following occupations were suggested as indicative of specific socioeconomic status categories:

Socioeconomic Status	Occupation
White Collar High	Owner high
	Manager and official high
	Professional self-employed
	Artist self-employed
	Professional employed by others

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[37]Langner, *op. cit.*, p. 69. Writing in 1963, Langner observed the income of the study's respondents: "Family income clearly reflects the 'Gold Coast and Slum' character of Midtown. Whereas 11.7 per cent have a family income under $50 a week, another 9.8 per cent have an income of over $300 a week. . . . Forty-nine per cent have incomes between $50 and $99 a week, making the modal income around $75 a week (p. 69)." If Langner's study were to be replicated today we assume that the income levels would be appreciably higher.

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White Collar Middle	Owner-proprietor middle Farmer high and middle (owner) Manager and official middle Artist employed by others Semi-professional Sales high
White Collar Low	Owner-proprietor low Manager and official low Sales and clerical low
Blue Collar High	Service high Skilled manual self-employed Farmer low Skilled manual employed by others
Blue Collar Middle	Semi-skilled Self-employed and employed by others
Blue Collar Low	Farmer low (tenant) Service low Unskilled labor[38]

For the purposes of the research in this dissertation occupation-level was assigned by referring to these categories. The reliability of the occupation-level assignment was tested by administering the Pearson product-moment correlation coefficient to the ratings given by other independent raters. Correlations of .94, .90, and .82 were obtained.

A third factor used in ascribing a socioeconomic status rating was the education (years of school, and degrees received) of the head of the household. This emphasis on the education of the head of the household is justified, but it is incumbent upon the researcher to beware of the upper-class bias that can become involved. The educational rating should be sensitive to semi-academic training in technical and trade

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[38] *Ibid.*, p. 232.

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schools, as well as special training programs which qualify the individual for a more prestigious, better-paying occupations.

The research in this dissertation has ascribed the amount of education to the five socioeconomic status groups, thus:[39]

Socioeconomic Class	Education (years of school, degrees, etc.)
Lower-class	0 - 8
Working-class	9 - 12
Lower middle-class	13 - 16
Upper middle-class	College graduate
Upper-class	College plus post-graduate work

The fourth determinant of socioeconomic status was the self-rating. Both the client and the counselor checked the question: "If you were asked to use one of these names for your social group, which would you belong to?" The counselor indicated his own rating of the client's socioeconomic status. Again the options offered were: Lower-class, Working-class, Lower middle-class, Upper middle-class, and Upper-class. The self-rating is a particularly important determinant of socioeconomic status for a number of reasons. Centers asserted that class membership is experienced in a sense of belonging and identification with one's own class and being opposed to other classes. For the purposes of our research it seemed important to determine not just the objective determinants of socioeconomic status but also an indication of the class which a person felt he belonged to, identified with, or

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[39] Leo Srole, *et. al.*, *Mental Health in the Metropolis* (New York: McGraw-Hill, 1962), p. 208 n. Srole used six categories: (1) some elementary school, (2) elementary school graduate, (3) some high school, (4) high school graduate, (5) some college, (6) college graduate.

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perhaps aspired to. It was deemed important to use this criterion of socioeconomic status in order to give an accurate rating to persons working at a low income while attending school, or for the exceptional cases, e.g., the educated professional's widow who stays home, does not work, and is supported by public welfare or Social Security payments.

The intake application also noted data not used to ascribe a socioeconomic status rating. It noted religion, address, employer, as well as whether the person had previous counseling.

Further information was obtained from the counselor. This information included the race of the client. Of the sixty persons included in the research the racial balance was:

Race	Per cent
Caucasian	82
Negro	8
Mexican-American	7
Oriental	3

The counselor reported the manner in which he was with the clients:

Mode of counseling	Per cent
Individual	50
Conjoint	39
Family	11

Although this approach of seeing clients in one of three treatment modalities does introduce another variable, it was not considered as a serious obstacle to the testing procedure. The research program had to be accommodated into the counseling procedures of the Family Service Association of Pomona. Every effort was made to carry out the

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research with the least possible disruption of the regular counseling procedures. Therefore, clients who came in alone were counseled individually, couples seeking counseling were seen conjointly, and parents seeking help with their children were seen as a family. The final tabulation of the results checked to see if the modality of counseling proved to be an uncontrolled variable which might distort the results. A Chi Square of the relation of therapeutic mode of counseling and goal congruence was not statistically significant.

None of the research group was included in a group counseling experience while the research was being conducted. Most couples coming for counseling were seen conjointly.

The counselors recorded the number of interviews of the clients in the research. The clients were seen as long as they felt the need for help through counseling. In most cases the counselors agreed with the clients when they concluded that they had handled the problem to their mutual satisfaction. The opportunity of returning for further counseling was left as an open possibility for the client.

On the follow-up test the counselor indicated the degree to which he offered the five therapeutic approaches and the degree to which he continued to aim for the four therapeutic goals.

Of those clients who terminated before or after completing five sessions, the counselor noted the reason for terminating. The counselor noted which of four reasons could be best applied to describe the reasons for terminating:

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Reason for terminating	Per cent
Client felt he accomplished his goal	53
Counselor only felt the goal had been attained	0
Both client and counselor felt the goal had been attained	20
Client did not follow through	27

It was felt that the information gathered in all the ways mentioned would supply sufficient data for the research proposed and described in this dissertation. On the basis on the data accumulated evaluations were made of the two major hypotheses of the research.

The Setting of the Study

The study was conducted beginning March 27, 1969, and running for three months at the Family Service Association of Pomona. The Family Service Association evolved from its earlier concept as a benevolent relief society into a relatively sophisticated nation-wide association of counseling agencies which attempt to help individuals and families solve problems judged to be amenable to short term counseling. The Family Service Association of Pomona serves Pomona, La Verne, San Dimas and Diamond Bar. Families in other communities are served by other Family Service agencies closer to their community. The Family Service Association of Pomona grew from the benevolent relief society with the charming name of the "Fruit and Flower Relief Society." Over the years the emphasis moved away from relief giving. Today the relief functions have been assumed by other community agencies and the Family Service

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Association is involved exclusively in counseling. The Family Service Association of Pomona is located at 746 North Gordon, a quiet street of old houses in an area of transition from single-unit residential to apartments and offices. The office is an old house, converted to supply a waiting room, secretary's office, and two counseling rooms. The clients who come for counseling are often referred by other agencies. The agencies giving the greatest number of referrals are the Department of Public Social Services, Tri-City Mental Health Authority, Schools, and the Los Angeles County Probation Department. Referrals are also made by doctors, lawyers, and ministers in the area.

Personnel

The counseling was done by Mrs. Jack Overturf, Mr. Sidney Tice, and Mr. Edwin Swenson. Mrs. Overturf and Mr. Tice have the M.S.W. degree and are members of A.C.S.W. (Association of Certified Social Workers). Mrs. Overturf counsels on a part-time basis. Mr. Tice is the executive director and case-work supervisor of the agency, and he also counsels a number of clients. Mr. Swenson has been accepted as a counselor on the basis of his B.D. degree and his work toward the Th.D. degree in pastoral counseling. Mrs. Lou Quinn is the secretary at the agency. Mrs. Quinn scored the T-JTA tests and helped the counselors coordinate the testing of the clients.

Questionnaire

Two questionnaires were administered to each client. The format

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for both questionnaires was similar. Part I of both questionnaires had 24 semantic differential adjectives to ascertain how the client evaluated himself on the emotional traits named. Part II of the first questionnaire utilized the same 24 semantic differential adjectives to ascertain the client's ideal of himself after five weeks of counseling. The second questionnaire sought to discover the client's ideal without placing a time of when he might hope to attain it. Part III of the first questionnaire sought to determine what goals or outcomes of therapy the client hoped for. The follow-up questionnaire asked the client's evaluation of the degree to which the desired outcome had been provided. Part IV sought to determine the techniques the client hoped the counselor would use to gain the desired outcome. The follow-up questionnaire asked the client's evaluation of the degree to which the counselor did, in fact, use the techniques he preferred. Part V asked three questions to gain important data. The questions sought to determine the degree to which the client felt he would be helped, the socio-economic class he felt he belonged to, and the main problem he sought help with. Part V of the follow-up questionnaire asked the degree to which the client felt he had been helped, as well as a question each to determine if the client felt his main problem seemed to change during the five weeks, and whether he saw the problem as more his own than he did before. The counselors answered the questionnaires to give both their evaluation of the clients' feelings and the goals and techniques to be sought with each client.

The tests were scored after the fifth week and the results were

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punched on IBM computer cards to facilitate evaluation of the results. A goal congruence score and four independent criteria of socioeconomic status were assigned to each client. Then the degree of positive or negative change was noted on the nine traits plus the attitude scale of the T-JTA test and on the 24 semantic differential items. The computer cards were then used in programs to find the results of the study.

Clients

The subjects in this research were 60 individuals who applied for and received counseling at the Family Service Association of Pomona. Only new intake clients were included in the research. The client population included 24 men and 36 women who were assigned to one of the three counselors as an opening for an appointment was available. Table I gives the basic information on the clients included in the research. Although this was not a random assignment of clients, no attempt was made to assign clients to any of the counselors for any special counseling need. This was done to meet agency needs to provide counseling as soon as possible. In effect this appeared to be a modified form of random assignment.

In no case did the counselors feel that one counseling session was adequate to help the client with his problem, yet five clients came for only the initial interview. It was assumed that continuation in counseling was one criterion of success in counseling, because the client would have to come in order to benefit from the counselor's

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TABLE I

DESCRIPTION OF THE CLIENTS IN THE STUDY

N = 60

		Per cent
Sex	Male	40
	Female	60
Age	15 - 19	15
	20 - 29	21.7
	30 - 39	33.5
	40 - 49	24.1
	50 - 55	5.0
SOCIOECONOMIC STATUS		
Income	Lower	6.7
	Working	31.7
	Lower-Middle	36.7
	Upper-Middle	18.3
	Upper	6.7
Occupation	Lower	8.3
	Working	56.7
	Lower-Middle	28.3
	Upper-Middle	6.7
	Upper	0.0
Education	Lower	8.3
	Working	63.3
	Lower-Middle	21.7
	Upper-Middle	5.0
	Upper	1.7
Self-Rating	Lower	3.3
	Working	38.3
	Lower-Middle	30.0
	Upper-Middle	28.3
	Upper	0.0
Times Seen	1	8.3
	2	15.0
	3	10.0
	4	8.3
	5	58.3

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TABLE I (continued)

Counselor seen	Overturf	20.0
	Swenson	63.3
	Tice	16.7
Presenting Problem		
Marital		41.7
Parent-Child		21.7
Situational		5.0
Emotional		25.0
Uncertain and Other		6.7
Type Interviews		
Individual		50.0
Conjoint		38.3
Family		11.7
Expectation of receiving help through counseling		
Client		
Low expectation		3.3
Middle		18.3
High expectation		78.4
Counselor		
Low expectation		1.7
Middle		13.3
High expectation		85.1
Evaluation of help received through counseling		
Client		
Low evaluation		18.3
Middle		13.3
High evaluation		68.4
Counselor		
Low evaluation		5.0
Middle		38.3
High evaluation		56.7

Goals selected by clients	Low	Middle	High[40]
Manipulation	28.4	30.0	41.7
Situational	8.3	13.3	78.1
Insight	16.7	13.3	70.0
Interpersonal	5.0	15.0	79.9

[40]Low, middle and high refer to the strength assigned to each goal.

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TABLE I (continued)

Goals selected by counselors (for the above clients)

	Low	Middle	High
Manipulation	60.0	13.3	26.8
Situational	6.6	5.0	88.3
Insight	10.0	3.3	86.7
Interpersonal	3.3	8.3	88.3

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advice, interventions, etc. The eight per cent figure of those who came for only one interview was actually lower than anticipated. Perhaps the tests administered had the effect of decreasing the percentage of clients dropping out after the first interview.

Much of the detailed information on the clients was ascertained from the intake application form.[41] The testing procedure involved asking each new intake client's cooperation in taking two tests. The client took the test after the first interview. The client was asked to take the tests in the agency's waiting room. The same procedure was followed after the fifth interview. In case a client did not continue coming for five sessions, he was called to come in to retake the tests after five weeks.

The selection of five weeks of counseling was made for a number of reasons. Family Service agencies try to provide short term counseling aimed at immediate situation change. This study, in part, intended to measure the changes that would occur in what is a very short time, undoubtedly far too short for any deep restructuring of personality.

On the basis of the information thus far provided we shall state the two major hypotheses of the research.

IV. RESEARCH HYPOTHESES

The two major hypotheses of the research in this dissertation were designed to test the effectiveness of counseling with clients of

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[41] See Appendix A for the Intake Application Form.

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divergent socioeconomic classes. The primary variable considered was client-counselor goal congruence. The first hypothesis stated:

> 1. Counseling will be more effective with clients whose goals are highly congruent with the goals of the counselor than with clients whose goals are of low congruence, as measured by four criteria: T-JTA tests, semantic differential tests, client and counselor evaluations, and continuation in counseling for at least five interviews.

Underlying the first hypothesis are three assumptions. First, as the client perceives that the counselor regards his therapeutic goal seriously, he will feel more respected by the counselor. It is assumed that the client would be able to become more deeply involved in the counseling process if he perceived the counselor's positive regard. Therefore, more progress was anticipated in the high goal congruence group. However, the counselor's proposal of further goal might convey to the client the perceptiveness, concern, and involvement of the counselor. Furthermore, it might be anticipated that the client who wanted the counselor to be an authoritative person upon whom he could depend would prefer perceiving the counselor's goals as different than his own. But with the exception of very dependent clients high goal congruence would be expected to go along with more effective counseling.

Second, client-counselor goal congruence is probably an indicator of the counselor's respect (unconditional positive regard) for the client, and as such, an important variable for his improvement.

Third, although the initial help sought is sometimes a cover-up, deception, for a more basic or long-standing problem, it is important that the counselor regard it seriously both as an opportunity to render immediate help, and to gain the confidence of the client.

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2. Working- and lower-socioeconomic status clients will tend to have a lower client-counselor goal congruence than will middle- and upper-socioeconomic status clients.

Three theoretical assumptions were implied in the second hypothesis. First, middle-class persons are both more familiar with and more in agreement with the goals of mental health and psychotherapy. Upper- and middle-class persons may regard counseling as a status-symbol. Working- and lower-class persons regard it as a stigma.[42] Furthermore, we would expect a higher goal congruence between middle-class clients and their counselors, because counselors tend to come from the middle-class and to identify with the middle-class values.[43] Centers wrote, "If one may speak of 'class' values, then the characteristic middle-class value is self-expression and that of the working class is security, for it is in relation to these desires that they differ most."[44]

Third, lower socioeconomic class clients tend to seek changed living conditions rather than behavior change (working-class goal) or intra-psychic insight leading to changed emotions (middle- and upper-classes). This is not intended as a value judgment of any socioeconomic

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[42]Hans J. Eysenck, *Uses and Abuses of Psychology* (Baltimore: Penguin, 1953), p. 193. Eysenck stated: "There is probably a marked positive correlation between incidence of neurosis and the material welfare of a country; in the United States it has become almost fashionable to have some form of neurotic disorder, and an upper-middle-class person is quite looked down upon if he cannot speak of 'his psychoanalyst' as having advised this, that, and the other."

[43]John P. Spiegal, "Some Cultural Aspects of Transference and Countertransference," in Frank Riessman, Jerome Cohen, and Arthur Pearl (eds.), *Mental Health of the Poor* (New York: Free Press, 1964), p. 314.

[44]Centers, *op. cit.*, p. 153.

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class. Rather, it is the assumption underlying the concept of differential treatment (and, therefore, differential goals) for different conditions. James McMahon wrote of the working-class psychiatric patient:

> One is impressed that the *actual experience* of *doing* and *struggling* toward a goal often brings more results and encouragement to the less sophisticated than all the attempts at time-consuming and penetrating self-analysis. . . . In dealing with the lower socioeconomic groups, it appears that immediate action and constant supportive encouragement augur well in overcoming the inertia that is due to the chronicity of their illness.[45]

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[45] James T. McMahon, "The Working Class Psychiatric Patient: A Clinical View," in Riessman, *op. cit.*, p. 292.

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CHAPTER VI

RESULTS AND CONCLUSIONS OF THE RESEARCH

This chapter gives the results and evaluations of the results of the research conducted for the purposes of testing the two major hypotheses of this dissertation. Insofar as it is possible the statistical results are shown in tables.

The goal congruence scores obtained by the clients ranged from a low of 20 to a high of 236, with the lower scores indicating higher goal congruence. The subjects were divided into two halves by assigning those with scores of 70 or lower to the high goal congruence group, and those with scores of 72 and above to the low goal congruence group. The split groups made it possible to compare the high and low goal congruence groups on a number of variables. The most important group of variables were those related to socioeconomic status. The fact that forty-one per cent of the clients rated themselves below the middle-class indicated that many of the clients had an awareness of the existence of and the composition of social classes. The Family Service Association of Pomona is supposed to serve all members of the community. The variety of client characteristics dispels the fear that counseling there is primarily a middle-class affair, in which middle-class counselors try to help middle-class clients.

I. HYPOTHESIS I RESULTS

Hypothesis I, stating that high goal congruence is related to

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more successful outcome in counseling, is borne out by some of the statistical interpretations of the data.

Number of Times Client Came

It was assumed that the client's continuation in counseling was a meaningful measure of the success of counseling, indicating the client's non-verbal evaluation that he was receiving benefit from counseling, or that he was confident that he would benefit by continuing in the counseling process. The Chi square scores are shown in Table II. The Chi square scores for the analysis of goal congruence by completion of five or more sessions (the number originally determined as completing the counseling process) was below the level of significance. However, the Chi square score for the analysis of goal congruence by completion of four sessions was significant at the .05 level. This would indicate that not only do more low goal congruence clients than high goal congruence clients drop out of counseling, but they do so early in the counseling process. If, however, they do not drop out of counseling their rate for continuing is not significantly lower than that of high goal congruence clients.

Improved T-JTA Scores

A further test of the hypothesis was the percentage of improvement on the T-JTA test. Table III indicates that the difference in the amount of improvement for high and low goal congruence clients was statistically significant for only one of the nine traits, Active-Social

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TABLE II

GOAL CONGRUENCE AND SUCCESS
(Determined by number of sessions client came for counseling)

Times Seen	Goal Congruence: High	Goal Congruence: Low
1	1	4
2	4	5
3	2	4
4	4	1
5 or more	19	16

$X^2 = 5.12$ DF = 4 Not Significant

4 Split (Came for 4 or more sessions)	Goal Congruence: High	Goal Congruence: Low
Yes	24	16
No	6	14

Chi Square = 4.8000 DF = 1 $P < .05$

5 Split (Came for 5 or more sessions)	Goal Congruence: High	Goal Congruence: Low
Yes	20	15
No	10	15

Chi Square = 1.71 DF = 1 Not Significant

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vs. Quiet. On two other traits, Depressive vs. Lighthearted and Hostile vs. Tolerant, the difference approached the level of significance. When the total improvement on all nine traits was compiled for each client, the difference again approached the level of significance. Although these results themselves do not confirm the hypothesis, they do point toward the possibility that the hypothesis might be borne out with the use of a larger group of clients. Furthermore, the fact that the high goal congruence group had scores superior to those of the low goal congruence group on seven out of the nine traits added more weight to the possibility that the first hypothesis can be accepted.

Improved Semantic-Differential Scores

The third test of the hypothesis was the degree of improvement on the semantic-differential instrument. Table IV indicates that the difference in the amount of improvement for high and for low goal congruence clients was statistically significant for only two of the twenty-four pair of adjectives (Pessimistic-Optimistic, and Successful-Unsuccessful). One other set of adjectives (Methodical-Disorganized) had a score approaching significance. Ten of the twenty-four pair of adjectives had higher improvement scores for the low goal congruence group than for the high goal congruence group. These results do not seem to be sufficiently different from those that might be obtained by chance to either support or detract from the hypothesis.

It is possible that the two pair of adjectives that were significant do measure a factor that is important in counseling, perhaps

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TABLE III

GOAL CONGRUENCE AND IMPROVED T-JTA SCORES

	GOAL CONGRUENCE			
T-JTA TRAIT	HIGH	LOW	F	P
A. Nervous vs. Composed	8.76	2.00	2.24	0.14
B. Depressed vs. Light-hearted	10.93	3.10	2.67	0.11*
C. Active-Social vs. Quiet	10.30	-1.63	6.37	0.01**
D. Expressive-Responsive vs. Inhibited	6.86	3.73	0.27	0.60
E. Sympathetic vs. Indifferent	3.76	-4.66	1.44	0.24
F. Subjective vs. Objective	3.90	1.36	0.33	0.56
G. Dominant vs. Submissive	0.40	5.13	1.97	0.17#
H. Hostile vs. Tolerant	1.93	-5.86	3.17	0.08*
I. Self-disciplined vs. Impulsive	5.00	9.76	1.24	0.27#
Attitude Scale	4.33	4.20	0.19	0.66
TOTAL IMPROVEMENT ON ALL 9 TRAITS	49.93	12.93	2.72	0.10*

Footnotes * = Approaching significance
** = Statistically significant
# = Low congruence scores are superior to high congruence scores

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being a measure of decreased depression while in counseling.

It is also interesting to note that with one exception all of the twenty-four scores for both high and for low goal congruence client groups do show an improvement. At most this would indicate the possibility that further more thorough research might find that the semantic-differential instrument as used here--or modified--might support the hypothesis relating high goal congruence to greater improvement from counseling.

Expectations and Evaluations of Counseling

The relation of expectations and evaluations of improvement by counseling as a function of goal congruence is presented in Table V. Both the client and the counselor had rated on a seven-point scale the degree of improvement expected from five weeks of counseling. When these ratings were related to the client's goal congruence score no significant relationship was found. In fact the low goal congruence group indicated a slightly higher expectation of improvement. Although there was no significant relationship of expectation to goal congruence, high levels of significance were obtained for the relationship of goal congruence and the evaluation of improvement.

Goal congruence was related to the client's self-rating of degree of improvement at the .03 level of significance. That is, those clients who were in the high goal congruence group evaluated the results of their counseling as more effective, or helpful. The relation of the counselors' evaluations to goal congruence was significant at the .01

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TABLE IV

GOAL CONGRUENCE AND IMPROVED SEMANTIC DIFFERENTIAL SCORE

T-JTA TRAITS	SEMANTIC DIFFERENTIAL ADJECTIVES	GOAL CONGRUENCE HIGH	GOAL CONGRUENCE LOW	F	P
A	Tense-Calm	5.03	4.30	1.69	0.20
B	Pessimistic-Optimistic	5.13	4.06	4.73	0.03**
C	Socially Active-Socially Inactive	4.06	4.60	1.02	0.32#
D	Affectionate-Unaffectionate	3.77	4.33	1.81	0.18#
E	Unsympathetic-Sympathetic	3.97	3.70	0.29	0.59
F	Logical-Illogical	4.27	4.23	0.01	0.93
G	Passive-Active	4.40	4.07	0.50	0.48
H	Tolerant-Intolerant	3.80	3.87	0.01	0.91#
I	Methodical-Disorganized	5.40	4.53	2.81	0.10*#
A	Nervous-Composed	5.07	4.10	2.54	0.12
B	Depressive-Lighthearted	4.53	3.80	2.38	0.13
C	Socially Involved-Socially Uninvolved	4.27	4.20	0.02	0.90
D	Expressive of Feelings-Emotionally Inhibited	4.50	3.77	2.48	0.12
E	Sensitive-Insensitive	3.63	4.33	2.09	0.15#
F	Subjective-Objective	4.60	5.10	0.86	0.36#
G	Dominant-Submissive	4.30	4.50	0.20	0.65#
H	Critical-Accepting	4.33	4.10	0.15	0.70
I	Self-Disciplined-Impulsive	3.80	4.17	0.84	0.36#
	Kind-Cruel	3.77	4.30	1.30	0.26#
	Strong-Weak	3.50	4.07	1.18	0.28#
	Insecure-Secure	4.83	4.80	0.00	0.95
	Successful-Unsuccessful	5.10	4.10	4.45	0.04**
	Serious-Humorous	4.53	4.17	1.05	0.31
	Calm-Excitable	4.90	4.73	0.09	0.76

*=Approaching Significance; **=Statistically Significant; #=Low Congruence

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level of significance. Thus, the counselors' and the clients' assessment of the effectiveness of the counseling were in agreement. It should be noted that the procedure to determine goal congruence was not tabulated until after the completion of counseling. Thus the counselors did not know which clients would be in the high goal congruence group. It is also interesting to note that both high and low goal congruence clients evaluated themselves as having improved during the five weeks of counseling. The counselors' ratings again agreed with those of the clients. The significant relation of goal congruence to evaluation of improvement supported the hypothesis relating high goal congruence to greater improvement through counseling. One attempt to further understand the meaning of this relation is shown in Table VI, indicating the degree to which each goal was chosen by the client and by the client's counselor.

The assessment of goal preference was made on the basis of the client and the counselor indicating his selection on each goal on two seven-point scales. When the clients' goal selections were related to goal congruence it was found that high goal congruence was related to the selection of the goal of insight at the .05 level of significance. It was further noted that low goal congruence was related to the selection of the goal of manipulation at the .09 level of significance. Although the latter is not statistically significant it is approaching significance and, therefore, is worthy of further investigation.

When the counselors' goal selections for their clients were related to goal congruence it was found that high goal congruence was

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TABLE V

EXPECTATION AND EVALUATION OF IMPROVEMENT
AS A FUNCTION OF GOAL CONGRUENCE

	GOAL CONGRUENCE			
	High	Low	F	P
Client's Expectation	5.83	6.00	0.18	.67#
Counselor's Expectation	5.30	5.40	0.15	.70#
Client's Evaluation	5.57	4.60	5.13	.03**
Counselor's Evaluation	5.13	4.47	7.04	.01**

* = Approaching significance

** = Statistically significant

= Low goal congruence scores superior

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TABLE VI

GOALS SELECTED BY CLIENT AND BY COUNSELOR
AS A FUNCTION OF GOAL CONGRUENCE

GOALS	GOAL CONGRUENCE			
	High	Low	F	P
Clients' Goals				
Manipulation	4.03	5.33	2.95	.09*#
Situational	7.87	6.83	2.42	.13
Insight	7.03	5.47	3.90	.05**
Interpersonal	7.80	7.03	1.49	.23
Counselors' Goals				
Manipulation	2.67	2.27	0.39	.54
Situational	7.77	6.63	4.98	.03**
Insight	6.70	6.53	0.08	.78
Interpersonal	7.70	8.00	0.39	.54#

* = Approaching Significance

** = Statistically Significant

= Low Goal Congruence Scores Superior

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related to the counselor's selection of the goal of situational improvement at the .03 level of significance.

II. HYPOTHESIS II RESULTS

Hypothesis II stated that working-class and lower-class clients would show a lower goal congruence than middle- and upper-class clients. This hypothesis was evaluated by obtaining the Chi square for the comparison of high and low goal congruence groups of clients by the four predetermined factors of socioeconomic status: income-level, occupation-level, education-level, and client self-rating-level. Table VII indicates that only one of these four factors, occupation-level, was statistically significant.

Conclusions about the relation of goal congruence and socioeconomic status can be drawn from evaluating the data to determine if the higher socioeconomic class clients experience more success on some measures. Insofar as socioeconomic status is related to success the relation of goal congruence to socioeconomic status should be noted as a possible factor of socioeconomic status.

Further work was done to test the relationship of goal congruence and each of the four socioeconomic status factors to changes in T-JTA scores. This is shown in Tables VIII through XI. These tables do not show any significant evidence for accepting the relationship between socioeconomic status and improved scores on personality trait inventories. Not even occupation-level, which was positively related to high goal congruence, when scored with goal congruence proved to have

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TABLE VII

GOAL CONGRUENCE AND FOUR SOCIOECONOMIC STATUS FACTORS

		GOAL CONGRUENCE		
		High		Low
INCOME LEVEL				
High		20		17
Low		10		13
Chi Square = 0.6345	DF = 1		Not Significant	
OCCUPATION LEVEL				
High		15		6
Low		15		24
Chi Square = 5.9345	DF = 1	P < .025	Significant	
EDUCATION LEVEL				
High		9		8
Low		21		22
Chi Square = 0.0821	DF = 1		Not Significant	
SELF-RATING LEVEL				
High		19		16
Low		11		14
Chi Square = 0.6171	DF = 1		Not Significant	

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TABLE VIII

GOAL CONGRUENCE AND INCOME LEVEL BY T-JTA IMPROVEMENT

	T-JTA TRAITS		GOAL CONGRUENCE High	Low	F	P
A.	Nervous vs. Composed	High	3.95	-4.11		
		Low	18.40	10.00	0.00	0.97
B.	Depressed vs. Lighthearted	High	11.50	2.18		
		Low	9.80	4.31	0.14	0.71
C.	Active-Social vs. Quiet	High	10.50	-1.18		
		Low	9.90	-2.23	0.00	0.96
D.	Expressive-Responsive vs. Inhibited	High	9.55	6.76		
		Low	1.50	-0.23	0.01	0.93
E.	Sympathetic vs. Indifferent	High	4.95	-4.53		
		Low	1.40	-4.85	0.05	0.83
F.	Subjective vs. Objective	High	2.50	1.47		
		Low	6.70	1.23	0.23	0.63
G.	Dominant vs. Submissive	High	-1.95	9.53		
		Low	5.10	-0.62	6.59	0.01**#
H.	Hostile vs. Tolerant	High	0.05	-6.82		
		Low	5.70	-4.62	0.14	0.71
I.	Self-Disciplined vs. Impulsive	High	6.00	7.82		
		Low	3.00	12.31	0.71	0.41#

* = Approaching Significance
** = Statistically Significant
\# = Low Goal Congruence Score Superior to High Goal Congruence Score

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TABLE IX

GOAL CONGRUENCE AND OCCUPATION LEVEL BY T-JTA IMPROVEMENT

	T-JTA TRAITS		GOAL CONGRUENCE High	GOAL CONGRUENCE Low	F	P
A.	Nervous vs. Composed	High	6.60	7.66		
		Low	10.93	4.41	0.58	0.44
B.	Depressed vs. Lightheated	High	8.86	14.50		
		Low	13.00	0.25	2.93	0.09*
C.	Active-Social vs. Quiet	High	11.13	-5.83		
		Low	9.46	-0.58	0.40	0.52
D.	Expressive-Responsive vs. Inhibited	High	7.60	12.83		
		Low	6.13	1.45	0.52	0.47
E.	Sympathetic vs. Indifferent	High	4.46	-10.50		
		Low	3.06	-3.20	0.29	0.59
F.	Subjective vs. Objective	High	0.26	1.33		
		Low	7.53	1.37	0.52	0.46
G.	Dominant vs. Submissive	High	-1.13	12.83		
		Low	1.93	3.20	2.81	0.09*
H.	Hostile vs. Tolerant	High	-5.93	1.83		
		Low	9.80	-7.79	7.32	0.01**
I.	Self-Disciplined vs. Impulsive	High	1.53	6.66		
		Low	8.46	10.54	0.09	0.75

* = Approaching Significance
** = Statistically Significant

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TABLE X

GOAL CONGRUENCE AND EDUCATION LEVEL BY T-JTA IMPROVEMENT

	T-JTA TRAITS		GOAL CONGRUENCE High	Low	F	P
A.	Nervous vs. Composed	High	7.77	-11.62		
		Low	9.19	6.95	3.18	0.07*
B.	Depressed vs. Lighthearted	High	13.11	4.00		
		Low	10.00	2.77	0.03	0.86
C.	Active-Social vs. Quiet	High	6.88	-1.00		
		Low	11.76	-1.86	0.29	0.59
D.	Expressive-Responsive vs. Inhibited	High	-3.66	3.12		
		Low	11.38	3.95	1.14	0.28
E.	Sympathetic vs. Indifferent	High	6.11	-8.50		
		Low	2.76	-3.27	0.29	0.59
F.	Subjective vs. Objective	High	1.88	-2.62		
		Low	4.76	2.81	0.06	0.79
G.	Dominant vs. Submissive	High	1.11	9.75		
		Low	0.09	3.45	0.49	0.48
H.	Hostile vs. Tolerant	High	-6.22	-6.62		
		Low	5.42	-5.59	1.21	0.27
I.	Self-Disciplined vs. Impulsive	High	2.66	-3.50		
		Low	6.00	14.59	2.66	0.10*

* = Approaching Significance

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TABLE XI

GOAL CONGRUENCE AND SELF-RATING BY T-JTA IMPROVEMENT

	T-JTA TRAITS		GOAL CONGRUENCE High	GOAL CONGRUENCE Low	F	P
A.	Nervous vs. Composed	High	5.37	4.82		
		Low	14.64	-1.69	2.96	0.09*
B.	Depressed vs. Lighthearted	High	8.21	2.24		
		Low	15.64	4.23	0.30	0.58
C.	Active-Social vs. Quiet	High	8.79	0.24		
		Low	12.91	-4.08	0.74	0.39
D.	Expressive-Responsive vs. Inhibited	High	7.74	1.53		
		Low	5.36	6.62	0.36	0.55
E.	Sympathetic vs. Indifferent	High	-1.05	-7.53		
		Low	12.09	-0.92	0.21	0.65
F.	Subjective vs. Objective	High	-1.53	2.00		
		Low	13.27	0.54	3.53	0.07*
G.	Dominant vs. Submissive	High	0.16	1.53		
		Low	0.82	9.85	1.25	0.27
H.	Hostile vs. Tolerant	High	-1.47	-7.76		
		Low	7.82	-3.38	0.30	0.58
I.	Self-Disciplined vs. Impulsive	High	4.58	11.35		
		Low	5.73	7.69	0.29	0.59

* = Approaching Significance

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more than one out of nine factors at a level of significance.

III. EXTRANEOUS FACTORS AND GOAL CONGRUENCE

A number of tests of comparison were conducted to show that none of the factors tested was largely responsible for the test results attributed to goal congruence and to socioeconomic status factors. The results of these tests are shown in Table XII. The factors tested were the sex of the client, the age of the client, the counselor seen, the presenting problem, and the way the client was seen. Further tests showed the relation of socioeconomic to T-JTA improvement and the relation of the counselor seen to T-JTA improvement. The results of these tests are shown in Tables XIII and XIV, respectively. The results of these comparisons indicated that none of these factors was basically responsible for the difference measured in the results.

The discussion of the test results will be treated in the following chapter on the importance of the results.

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TABLE XII

EXTRANEOUS FACTORS AND GOAL CONGRUENCE

Goal Congruence and Sex of Client

Sex of Client	Goal Congruence	
	High	Low
Male	11	13
Female	19	17

$X^2 = .28$ df = 1 N.S.

Goal Congruence and Age of Client

Age of Client	Goal Congruence	
	High	Low
15-19	4	5
20-29	8	5
30-39	8	11
40-49	8	7
50-55	2	2

$X^2 = 1.37$ df = 4 N.S.

Goal Congruence and Counselor Seen

Counselor	Goal Congruence	
	High	Low
Overturf	7	5
Swenson	20	18
Tice	3	7

$X^2 = 2.02$ df = 2 N.S.

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TABLE XII (continued)

Goal Congruence and Presenting Problem

Presenting Problem	Goal Congruence High	Low
Marital	12	13
Child	5	8
School or work	1	2
Emotions	11	4
Uncertain	1	2

$X^2 = 4.2$ df = 4 N.S.

Goal Congruence and Way Seen

Way Seen	Goal Congruence High	Low
Individually	16	14
Conjointly	11	12
Family	3	4

$X^2 = .62$ df = 2 N.S.

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TABLE XIII

SOCIOECONOMIC STATUS (OCCUPATION-LEVEL) AND T-JTA IMPROVEMENT

		OCCUPATION LEVEL			
	T-JTA TRAIT	High	Low	F Ratio	P
A.	Nervous vs. Composed	2.52	6.92	.84	.36
B.	Depressive vs. Lighthearted	10.47	5.15	1.09	.30
C.	Active-Social vs. Quiet	6.29	3.28	.33	.57
D.	Expressive-Responsive vs. Inhibited	9.10	3.26	.86	.36
E.	Sympathetic vs. Indifferent	.19	-0.79	.02	.90
F.	Subjective vs. Objective	.57	3.74	.48	.49
G.	Dominant vs. Submissive	2.86	2.72	.00	.97
H.	Hostile vs. Tolerant	-3.71	-1.03	.33	.57
I.	Self-Disciplined vs. Impulsive	3.00	9.74	2.31	.13
	Total on all 9 Traits	33.29	30.44	.014	.91

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TABLE XIV

COUNSELOR SEEN AND T-JTA IMPROVEMENT

		COUNSELOR SEEN				
	T-JTA TRAIT	OVERTURF	SWENSON	TICE	F RATIO	P
A.	Nervous vs. Composed	3.17	7.13	1.40	.53	.59
B.	Depressive vs. Lighthearted	7.25	8.34	1.70	.49	.62
C.	Active-Social vs. Quiet	6.00	3.79	4.40	.06	.94
D.	Expressive-Responsive vs. Inhibited	3.42	8.34	4.20	1.19	.31
E.	Sympathetic vs. Indifferent	9.58	3.32	3.80	1.11	.34
F.	Subjective vs. Objective	1.17	2.34	5.50	.19	.83
G.	Dominant vs. Submissive	.25	2.61	6.40	.60	.55
H.	Hostile vs. Tolerant	2.83	2.16	7.00	.87	.42
I.	Self-Disciplined vs. Impulsive	4.33	7.24	11.60	.52	.60

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CHAPTER VII

THE IMPORTANCE OF THIS STUDY

The research reported in this dissertation has attempted to evaluate the effectiveness of short-term counseling at the Family Service Association of Pomona as a function of the client's socio-economic status and of the client-counselor goal congruence. The research results reported in Chapter VI indicate that the first major hypothesis could be tentatively accepted. The null hypothesis stating that goal congruence is *not* related to client improvement in a statistically significant manner was rejected. However the second hypothesis, that the socioeconomic status of the client is related to his goal congruence score, was not established. The high goal congruence clients did tend to be represented by the higher socioeconomic status factors, but not to a significant degree. The task at this point is to discuss the implications of these findings. What is the importance of goal congruence? How does a client's socioeconomic status relate to the effectiveness of the counseling he receives?

I. IMPORTANCE OF THE CLIENT'S SOCIOECONOMIC STATUS FOR COUNSELING

Much research in the last decade had indicated that a barrier impedes the effectiveness of the middle-class counselor with a lower-class client. Lower-class membership was also found to be related to the incidence of mental illness, and to the lower quality of psychotherapy provided. Those research findings left many questions

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unanswered. Does low socioeconomic status predispose persons toward mental illness, or do persons with inferior mental health tend to remain in the lower-class? Does low socioeconomic status make clients less able to benefit from short-term counseling, or do counselors tend to offer less helpful counseling, i.e., do the counselors tend to give up too easily with clients from the lower-class? Does low socioeconomic status make clients less likely to agree with the counselor on the preferred outcomes and techniques of counseling, or do counselors tend to have more limited goals for lower-class clients? In evaluating the previous research the relation between class membership and mental health factors is obvious, but it remains to be demonstrated which is cause and which is effect. Furthermore, the question of the meaning of the previous research projects is yet to be fully explicated. Is the observed relationship between low socioeconomic status and a higher incidence of mental illness merely coincidental or actually one of cause and effect?

The relationship between lower socioeconomic status factors and lower goal congruence hypothesized in this dissertation was borne out in only one out of four demographic factors, occupation-level. Since higher goal congruence was related to more effective results from counseling, as hypothesized, a relation of socioeconomic status to goal congruence would have strongly implied that lower socioeconomic status clients would generally receive less help than individuals of higher classes from the counseling offered at the Family Service Association of Pomona. Therefore, the results of the research reported in this

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dissertation would at least imply that the incidence of higher goal congruence, and of more effective counseling, cut across class lines on three out of four status factors. If replication substantiates the validity of these findings it may suggest that class membership is not as important a variable in counseling as implied in previous research. Research into the factors behind the results in the previous research may begin to divulge the explanations of why lower-class clients seemed to receive less help from counseling. Perhaps the concept of goal congruence will offer one factor that can be utilized across class barriers in explaining the disproportionate effects of the counseling offered.

To the extent that a status gap does exist in counseling, attempts should be made to understand it and to explicate the directions it necessitates that counseling move to overcome the gap. Previous research has indicated that a chasm separates the middle-class counselor from the lower-class client. The chasm yawns between them in spite of, and perhaps because of, the good intentions on both sides of the gap. The socioeconomic status gap sets a success-oriented middle-class counselor across the desk from a lower-class client who views success in different terms than the counselor, i.e., low goal congruence exists. The gap makes it difficult for counselor and client to communicate at the level of feelings. The counselor may further complicate the communication process by his efforts to bend over backwards to not be prejudiced against the client. This effort may blind the counselor to obvious symptoms and behavior which exacerbates the client's problems

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in life. Furthermore, the client may sense and resent the condescension of the counselor's attempt to tolerate traits or behavior which he believes the counselor would condemn in his middle-class neighbor. The lower-class client may further cloud the communicative process by trying to anticipate what the counselor wants to hear and trying to comply. Many persons, regardless of socioeconomic status level, find it difficult to reveal their problems and their feelings to a counselor. There are many barriers impeding the potentially therapeutic interaction between counselor and client. The socioeconomic status gap does not make communication and counseling impossible. It may make it more difficult. Hopefully, training and supervision that draw the counselor's attention to this gap, and to the way he attempts to bridge it, will begin the process of reducing the barrier and thereby enhancing the potential utility of the counseling offered.

The hypothesized relation between three of the four socioeconomic status factors did not materialize in the results. Only occupation-level was statistically related to goal congruence. Although this did not allow for the acceptance of the hypothesis, it necessitates speculation on the relation between occupation-level and goal congruence. Does the occupation a person holds affect the manner in which he will relate to counseling as a way of solving some of his problems? Kornhauser indicated a possibility of this in evaluating the mental health of factory workers.[1]

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[1]Arthur Kornhauser, "Toward an Assessment of the Mental Health of Factory Workers," in Frank Riessman, Jerome Cohen, and Arthur Pearl (eds.), *Mental Health of the Poor*(New York: Free Press, 1964).

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A second possibility is that the type occupation a person holds is less likely to change than is his income, education, or his feelings about his position in the social structure. Organized labor has made it possible for carpenters, plumbers, welders, etc., who work most of the year to earn more money than many of their white collar neighbors. Furthermore, adult education enables many persons to complete their high school education in later years even if they did not remain in school originally. It would be assumed that in the United States, with its American Dream of upwardly mobile social and economic levels, persons who earned more money and perhaps adopted some of the middle-class values of split-level suburban homes and the attempt to push their children to get more education would come to think of themselves as in a higher social class. If, in fact, occupation-level is a more accurate indicator of social class, then the other three factors shown in Table VII of the preceding chapter point to the possibility that hypothesis II might be accepted with further research, especially if that research included a larger sample.[2]

In addition to speculating that occupation-level may generally tend to remain more stable and therefore be a better predictor of social class than the three other demographic factors, comments must be made on the obverse, on the absence of a statistically significant

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[2]S. M. Miller and Elliot C. Mishler, "Social Class, Mental Illness, and American Psychiatry: An Expository Review," in *Ibid.*, p. 26. The authors stated that occupation-level appears to be the best demographic factor determining socioeconomic status.

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relationship between income-level, education-level, and self-rating-level and goal congruence. It was assumed at the outset that these factors would have made the client respond in a more predictable way. The Hollingshead Index of Social Position utilized similar factors and the research in New Haven showed remarkable class differences. Yet those differences were largely absent in this research on goal congruence.

It would seem logical to speculate that these three factors have a more superficial effect upon the person. Although he may have the income and education of the higher classes, and although he may claim to believe he is a member of the higher classes, he may not believe it at a deeper level, especially when he knows that he must get up early, don work clothes, and work all day with his hands. A further speculation would be that goal congruence is not so much related to social class as was previously anticipated.

Socioeconomic Status and Goal

In this research the counselors selected the goals which seemed most likely to be useful to the client at the present time. The anticipated divergence of counselor-selected goals did not materialize. This may have been because of the fact that all of the counseling was short-term. Had the counseling not been limited to short-term the anticipation was that counselors would have tended to select insight goals more often for higher-class clients and situational improvement for lower-class clients.

My conclusion from the results of the research reported in this

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dissertation is that the counselor must have an awareness of the dynamics of socioeconomic class membership so he can evaluate objectively the goals selected by his clients. If the counselor's evaluation is that the client has selected a goal that will be beneficial to him, the counselor should cooperate in pursuing that goal, thereby creating higher goal congruence.

Although the counselor may personally prefer permissive parental roles, he will be willing to help the lower-class family stabilize a more restrictive parental role. The counselor's role is not to proselytize clients to his convictions but to assist clients to fulfill the roles they have selected and by which they can best integrate themselves into their community. This does not require the counselor to give bland acceptance to whatever goal the client requests. The counselor has the responsibility of drawing the client's attention to his stated goal and seeking to evaluate if it is the most important goal, i.e., both client and counselor must openly discuss the goals they seek, and they must both decide whether they can work with the other's goal.

Socioeconomic Status and Defenses

A further relation may be found to exist between socioeconomic status and the client's choice of defenses. Whereas the upper-class client might play "wooden-leg," i.e., referring to bad developmental experiences to excuse himself from the need to change, the lower-class client might vent anger at the counselor for his attempts to make

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him change.[3]

Any client, regardless of his socioeconomic status, seeks counseling because he is experiencing pain and he is dissatisfied with himself (or with his wife, child, or general situation). Therefore, we must note what relation socioeconomic status has to the probability of the client actually experiencing change.

The results of this research indicated that most clients in counseling experienced change regardless of their socioeconomic status. However, positive changes indicative of effective counseling were noted to be related to higher occupation-level. This was not surprising since a great deal of previous research has indicated that counseling as conventionally practiced is alien to working- and lower-class clients. The point that was surprising was the great degree of variation within socioeconomic classes and the relatively small cumulative differences between the class groupings. This tended to confirm the viewpoint that socioeconomic status is not the only important variable in predicting the probability of positive change during counseling. The effectiveness of counseling might be enhanced if more diagnostic efforts were expended in attempting to assign a particular client to a counselor who had been shown to be more effective with previous clients expressing a similar concern.[4]

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[3]Richard A. Hogan, "A Measure of Client Defensiveness," in Werner Wolff and Joseph A. Precker (eds.), *Success in Psychotherapy* (New York: Grune & Stratton, 1952), pp. 112-142.

[4]Robert C. Carson and Ralph W. Heine, "Similarity and Success in Therapeutic Dyads," in Arnold P. Goldstein and Sanford J. Dean (eds.),

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II. IMPORTANCE OF THE CLIENT'S GOALS

Importance of Goal Congruence

There is a contention that the counselor should be very suspicious of a client's stated goal for counseling. Insight-oriented counselors often assume that the client's problem is a result of his failure to accurately label his feelings, thoughts, goals, etc. The young couple claim they want to marry because they love and need each other, when a more accurate statement might be that they wish to escape intolerable home situations. The frustrated couple may complain that they remain married only because of the children, whereas they are in fact afraid to acknowledge how deeply dependent they have become on each other. However, the client may be able to make changes that will be helpful to himself and to others in his life as he deals thoroughly with the issues of the present. Whereas the insight-oriented counselor would feel compelled to help his client see and acknowledge his deeper goals the non-insight-oriented counselor could more readily accept the client's goal as valid and help him find ways of achieving it. This acceptance would be based on the wider number of goals that the non-insight-oriented counselor finds acceptable, e.g., happiness, productivity, and the increased ability to live in harmony with family and associates. The counselor could openly state his disagreement in order to work toward a workable counseling arrangement. In either case the chances

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The Investigation of Psychotherapy (New York: Wiley, 1966), p. 352.

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of counseling being effective would be greater when client and counselor are agreed on the goal of counseling. As noted in Chapter VI, the client with a low goal congruence may tend to drop out of counseling thereby obviating any chance of being helped.

Furthermore, the counselor who pursues insight or interpersonal relationship goals could effectively utilize the client's stated goal to ascertain where the client's further problems lie. The parent who seeks as his goal the control of his child's behavior may be subtly indicating his fear of what the child might do and of the effect it might have on the parent. The wife who complains of her suspicions of her husband may be indicating her need to control her husband's behavior, albeit through the tactic of keeping him on the defensive. Many therapists feel that all behavior, all symptoms, the very way the client speaks or sits, point in non-verbal ways to the deeper aspects of the client's personality. Therefore, the counselor who enhances goal congruence by seeking to understand the client's goal, and where agreeable accept it, would be enabling the client to resolve some of his deeper problems in the process, even though those problems might not be consciously acknowledged.

The research in this dissertation evaluated the effectiveness of counseling as a function of: 1) an overall score indicating the client-counselor agreement on the preferred outcomes and approaches for counseling, and 2) a series of four scores indicating the degree to which client and counselor agree on the four preferred outcomes. The results indicated that higher goal congruence was related to better results

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from counseling. This might be misleading if the higher goal congruence had been related to the client's higher socioeconomic status. This would raise the possibility that goal congruence is only an intervening variable. However, it might also indicate that the counselor is better able to understand and relate to high goal congruence clients regardless of the socioeconomic status of the client or of the counselor.

Goals of Counseling

The selection of and agreement on the goals or preferred outcome of counseling is particularly important. The agreement indicates the degree to which the counselor and client are in harmony in trying to accomplish an agreed upon goal. If agreement is lacking, the counseling might be at cross purposes. For instance, a parent might be seeking to continue his dominance of a child who is expressing adolescent rebelliousness. The counselor who tried to persuade the parent to be more tolerant of his teenager's behavior might find himself in a battle with the parent. The outcome of the battle would probably be a willingness of the client to change his goal or the cessation of counseling. There should be other alternatives, such as the continuation of counseling with a compromise goal that satisfied client and counselor. Ideally the counselor should seek to relate to the person in such a way as to understand the deeper significance of his goal. Thus there could be a basic goal congruence of respecting the client while agreeing to have theoretical differences about how to reach that goal. We shall now discuss the theoretical differences, or the approach selected.

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Psychotherapeutic Approach

To some extent the counseling approach selected would fit the preferred outcome. Thus the selection of the goal of insight would probably accompany the selection of the approach of non-directive listening to and restating of the client's statements. In this research many clients chose all five approaches to about the same degree. Some apparently saw no conflict in choosing both non-directive and directive approaches. The counselors were more informed about and aware of the approaches available than the clients were and therefore the counselors tended to pick a particular approach for each client. The counselor probably could have guessed with a fair degree of accuracy the approach which each client would select. However, the research asked only for the approach the counselor felt would be most effective, on the basis of his initial interview with the client.

The ideal for counseling would seem to be the workable contract between the client and the counselor on both the goal and the approach for counseling. The contract should be one which can be renegotiated periodically as the counseling progresses. This already occurs but is not acknowledged in much counseling.[5]

III. IMPLICATIONS OF THIS RESEARCH

The results of this research have implications for the field of

[5]Harry C. Bredemeier, "The Socially Handicapped and the Agencies" in Riessman, *op. cit.*, p. 107.

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counseling and psychotherapy in general because of the importance of the counselor's understanding the goals of his client. Insofar as the client's socioeconomic status affects his goals the second theme of this research has implications for the ways in which the counselor can seek to understand and work with the client who comes to him. In order to see some of these implications in more detail they will be applied specifically to the counseling offered at the Family Service Association of Pomona and to the field of pastoral counseling and pastoral care.

Implications for the Family Service Association of Pomona

A number of implications for the Family Service Association of Pomona were noted. The research reported in this dissertation was one of the first attempts at the agency to evaluate the effectiveness of the service offered. The study helped the counselors begin to focus on the relation of the client's socioeconomic status to his style of life and therefore his desired goals in counseling. And finally, the emphasis on the goals of counseling served the two-fold purpose of exploring the dynamics of drop-outs from counseling as well as the relation of the goals offered to the client's ability to make use of the counseling.

Evaluation of Counseling. This study was the first attempt made to ascertain the effectiveness of the counseling offered and received at the Family Service Association of Pomona. Prior to this study the

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only criteria of success were the counselor's subjective evaluation at the conclusion of counseling and the occasional client who would comment on some of the ways in which the counseling helped or failed to help him. This should not be taken as a criticism of the Family Service Association of Pomona, because it would seem that much counseling makes no attempt to evaluate the client before and after counseling and to establish workable definitions of effectiveness on the basis of more or less objective criteria. Prior to the time of beginning the research the Family Service Association of Pomona began administering the T-JTA test to incoming clients but no attempt was made to give the test again at the completion of counseling. Part of the reason no follow-up test was given was the fact that the clients would often drop out of counseling without giving any notice. Since they did not come to the office to discuss terminating, little opportunity was afforded to evaluate objectively the progress they had made.

A further reason for the sparsity of objective evaluations of the progress clients make in counseling is the difficulty in deciding what constitutes progress for the client. The client may feel that he has benefited from counseling whereas the objective personality tests may indicate either no change or a change in the direction assumed to be negative. The lack of clear-cut definitions of counseling effectiveness and of acceptable ways to measure that effectiveness discourages many from even attempting to isolate and measure factors of change. This same lack of clear definitions and acceptable testing devices posed a large problem for the research attempted in this dissertation.

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The problem was tackled by using a number of measurements of the progress in counseling. In addition to the T-JTA a semantic differential instrument, a count of the number of sessions the client completed, and the subjective evaluations of the help received were recorded. This procedure helped give a more balanced picture of the changes during counseling. It also guarded against the counselor's anxiety that the client might score worse after counseling on some measures. Although the counselors might develop a facility for explaining that the client has to get worse before he can get better, or that the measure used really was showing that the client was now more free to acknowledge and express his feelings and therefore appeared to be more upset, etc., but the fact would remain that counselors do tend to be sensitive to the desire to be successful and that desire might impede their being scientific about the changes measured. In undertaking the research the counselors were aware that the tests might indicate that clients who receive counseling are worse after counseling, and much worse after much counseling. With fear and trembling the tests were administered and later scored and tabulated. As suspected some clients did score worse on the retest, while some scored better. Even when the T-JTA changes on the nine traits were added together some clients had scores indicating very little improvement. However, when the totals for each client were compiled there was an indication that clients coming for counseling do indeed change in the direction that the T-JTA test designated as positive. This result, combined with the fact that clients do keep coming for counseling and that they express satisfaction with

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the changes they make, indicated that the Family Service Association of Pomona is meeting some of the needs of its clients. It also raises the more far reaching questions of the degree to which it meets the client's needs, which needs are fulfilled and which are unfulfilled, and which clients tend to receive more help from the service. These questions point to the need for further research, speculation, and perhaps, the revision of the way counselors attempt to help their clients. One of the major concerns of the Family Service Association of Pomona is that it serve all segments of the community. Therefore, the examination of the socioeconomic status of the clients proved very enlightening, indicating that all social classes are represented among the clients.

Socioeconomic Status of the Clients. There is a widespread suspicion, supported by previous research, that counseling services tend to be utilized primarily by the middle-class, leaving the working- and lower-class person at the mercy of his own means of coping with his problems. But in the research reported in this dissertation over fifty per cent of the clients were in the working- and lower-class. This may be accounted for by the number of working- and lower-class clients who were encouraged by social workers, probation officers or school personnel to seek counseling at the Family Service Association of Pomona, which has a graduated fee schedule that makes it possible for any person desiring and/or needing counseling to obtain it. This is not to imply that working- and lower-class clients came only because

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pressure was exerted on them, or that middle-class clients always came without any pressure. No accurate measurement of this factor was recorded, although it would now appear to be one worth incorporating and implementing in further research.

Even if working- and lower-class clients had come only under pressure from outside authorities they would not have continued coming or have entered into the counseling relationship had they not felt that counseling would be helpful to them personally. Many clients coming under duress of external pressure, from authorities, spouse, or parents, quickly perceived that the counselors were not taking sides with the authority against them. Once that was established the client seemed to feel reassured and entered into the counseling relationship as an attempt to alleviate some of the problems he was experiencing. Since no significant relationship between the client's socioeconomic status and his continuation in counseling was established, it was assumed that socioeconomic status presents only an initial difficulty in forming a counseling relationship, and that the counselor often has the ability to relate to the client's needs more personally unhampered by a disparity between his own and the client's socioeconomic status. This is not to argue that class distinctions do not exist, or that they are very superficial. It is rather to assert that the counselor and client can acknowledge the differences in their style of life and then relate to each other at the level of persons who have needs to be loved and to love, who have needs to feel that they are living a worth-while life, and that they are included in a caring community. Both client

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and counselor may be aware of the different manifestations these needs will take, but they can work together in helping the client to meet his needs in ways that are satisfying to him. It was assumed that the counselor felt a fuller sense of accomplishment after helping the client meet these needs than he would by having tried to coerce the client to change his style of life to one more like that of his middle-class counselor. But the counselor who foisted such a change on his client could not help but know that the client was probably only pretending to have changed.

Drop-outs. The Family Service Association of Pomona, like many other agencies serving working- and lower-class clients, faces the problem of clients who drop out of counseling. This presents a number of problems. For one the client who drops out fails to receive the help he wants and needs. Also the agency finds that valuable counselor time is lost when a client comes for an intake interview, accepts an appointment to return, but never returns. Clients who could have been seen at that time are also left without help. One of the facts noted from the research was that the percentage of persons coming for only one interview decreased markedly. Whereas in the previous year thirty-four per cent of the clients came for only one interview, the percentage of clients in the research coming for only one interview dropped to less than nine per cent. This was a valuable change for the agency. The change might have been at least partly the result of the more thorough testing of the clients. The battery of tests might have elicited

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a higher initial involvement in the counseling process. It may also have been interpreted by the clients as a tangible indication of concern by the agency. In any case the reason for this welcome change is not definitely known. A further test of the hypotheses of the change might prove to be a project of value for agencies serving lower- and working-class clients.

The research reported in this dissertation focused on the goal congruence score of the client as a factor that proved to be significantly related to continuation in counseling. The concept of goal congruence might prove useful to counseling agencies by enabling them to ascertain early in the counseling process those clients who would be more likely to drop out and to focus on ways to openly discuss the goals and agree on ways that the client can attain the help he wants from the agency. This might be increasingly important as various minority groups organize to demand that they have counselors who are members of their group. This is seen especially on college campuses where black and brown students are demanding that they have counselors of their own ethnic and racial background. These demands undoubtedly have some validity. But carried to the extreme it would seriously hinder the counseling professions if all differences were assumed to be insurmountable barriers. It is to be hoped that the goal congruence concept will give some direction for those seeking to have counseling help clients by encouraging them to see the differences and deal with them. It is also to be hoped that counselors will take the students' demands seriously as an indictment of the counselor's unconscious

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prejudices to which the student rightfully objects.

Implications for Pastoral Counseling

The research results reported in this dissertation have many of the same implications for pastoral counseling as they had for counseling at the Family Service Association of Pomona. Pastoral counseling centers might find value in the labor involved in defining the criteria of effective counseling, and then they might give birth to results indicating what groups of persons seek help in a pastoral counseling center and to what degree they get help for the needs which motivated them to enter the counseling relationship.

Evaluation of Counseling. Pastoral counseling centers have many of the same criteria to evaluate the effectiveness of counseling as do community counseling agencies. Both are concerned to help the client explore, clarify, and reduce the pain he experiences. Both are interested in assisting individuals, couples, and families in their struggles to live in greater harmony, and to relate their true feelings, thoughts, and needs to "significant others." Beyond these concerns many pastoral counselors and counselors in public agencies are concerned to help persons not just accommodate themselves to society but to struggle creatively to reform society. Insofar as the counselors in both settings are working to accomplish these goals they would be able to evaluate the effectiveness of counseling by the same criteria, e.g., personality and projective tests, evaluative questionnaires, etc. But

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pastoral counselors can utilize a further evaluative criterion of the counseling offered to the client. Hopefully, the pastoral counselor is able to relate in meaningful ways to the religious dimension of clients' lives.

This is not to imply that other counselors are not capable of exploring the meaning of the client's religious life, or that other counselors would studiously avoid the discussion of religion. Nor is it implied that the pastoral counselor is concerned exclusively or zealously with the religious dimension of each client's life. Rather, the pastoral counselor, by virtue of his theological and psychological training, his sensitivity, and his personal identity, is able to look past the outward signs of the client's religious practices (or absence thereof) to the central meaning that life has for the client. He is able to explore these meanings with the client, perhaps providing theological labels for psychological ones, and note the degree to which the client in counseling confesses sin (becomes honest about the unacceptable aspects of himself), experiences the results of sin (alienation), accepts grace (acceptance) and grows in grace (matures). The religious aspect in counseling is not an extra feature so much as a deeper understanding of the transcendent significance of the results of counseling.

A goal congruence instrument would enable the counselor to tell which clients wished simple relief from stress and which sought to grow in their relationships to others and to the ultimate. An adaptation of the goal congruence instrument would enable the counselor to see which

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clients would benefit from a variety of therapeutic modalities which could be provided.

The concept of socioeconomic status would provide a tentative clue to the client's preference in the forms of religious experience, type of church or sect in which to worship, way of relating religion to personal and community life, nature and degree of social concern, etc. The counselor could hopefully get past the superficial differences of religious style to the basic meanings of the style, church and witness for the client. All clients stand in need of the same grace or love which they can experience in a variety of ways because of their divergent life-styles.

Relating to Client Strengths. The concept of goal congruence should enable the counselor to acknowledge socioeconomic status and sociocultural differences and move to mutual understanding at the level of the common religious dimension behind the different forms of expression. Thus the pastoral counselor need not feel the burden of converting the client to his life-style. The pastoral counselor can find and utilize the strengths inherent in the client by enabling the client to relate to the counselor in an atmosphere of grace and acceptance. In the process of relating, the client and counselor could come to appreciate the strengths inherent in, although perhaps dormant, the client.

Implications for Pastoral Care

The pastor or minister in a parish situation has many more brief

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contacts of pastoral care than he has structured intense pastoral counseling situations. Almost any meeting with parishioners or other persons in his community provides a potential opportunity to express pastoral care. The minister is on duty twenty-four hours a day, at least insofar as his witness of pastoral care involves a total commitment. Perhaps the pastor practices pastoral care more during unofficial contacts with individuals than during the times he functions in the traditional roles of preaching, visiting the sick, etc. The helpfulness of the pastoral care is enhanced by the degree of sensitivity, maturity, and honesty inherent in the pastor.

The pastor does not have the opportunity to administer tests to determine socioeconomic status, life-style, or goal congruence of each person he encounters. The pastor must develop the ability to assess and guess these factors from his conversations. On the basis of such an assessment the pastor can accommodate his goals to those of the other person so that a high degree of mutuality can release the strengths of both persons--pastor and parishioner--to live the moment as fully as possible and thereby arrive at results satisfying to both.

The failure of a pastor to estimate and to enhance goal congruence leads to much of the frustration with the church experienced by both pastor and parishioner. I experienced the frustration, anger, and loneliness of low goal congruence while trying to organize parishioners to support a social concern (race relations) generally unpopular in the community. Only with the wisdom of hindsight do I see the degree to which my urgings and preaching on issues important to me were

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monological rather than dialogical. I tended to enhance low goal congruence by not listening for feedback on my ideas and suggestions. Fearing that I would not be able to lead the flock in the "right" way I reacted defensively, assuming that not succeeding in getting my way would lead to ultimate failure for the church.

Now I am increasingly convinced that the pastor can state his goal as honestly as possible, encourage the parishioners to do likewise, and then if a contractual relationship can be formed, proceed with the work at hand. This would force the termination of some contracts, reduce the number of frustrating and phony relationships, and eliminate the power games played by bluffing.

IV. FURTHER RESEARCH

The work of this dissertation could be enhanced by further research to determine if the results would be the same. A simple replication could test to see what differences were noted in the results. It would be interesting to repeat the study in an agency serving a larger percentage of lower-class clients to see if goal congruence can be utilized to comprehend and overcome the differences noted between divergent socioeconomic classes.

In further research it would be worthwhile to alter some of the procedures. It would be good to do the study in an agency with a larger number of counselors, and include a larger number of clients, than included in this study. It would also be interesting to test the results based on ten or more weeks of counseling, since five weeks

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hardly allowed for anything more than superficial changes. It would also be worthwhile to revise the semantic differential instrument to measure the qualities Osgood measured. The goal congruence instrument could be adapted to be used in any number of agencies--to test the concept of goal congruence in a variety of settings.

V. SUMMARY

The research reported in this dissertation was designed to evaluate the differential in the effectiveness of short-term counseling at the Family Service Association of Pomona during a three-month period as a function of counselor-client goal congruence and of the client's socioeconomic status. Special attention was directed to recent research on the relationship of mental illness and low socioeconomic status. Notable among these researches were Hollingshead and Redlich's *Social Class and Mental Illness* and Langner's *Life Stress and Mental Health.*[6] Many observations on the relation of socioeconomic status to mental illness, as well as suggestions for more effective therapeutic intervention, were suggested in articles compiled in Riessman's *Mental Health of the Poor.*[7]

This research was based on the results of tests taken by sixty new-intake clients coming to the Family Service Association of Pomona.

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[6]August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness* (New York: Wiley, 1958); and Thomas Langner and Stanley T. Michael, *Life Stress and Mental Health* (Glencoe: Free Press, 1963).

[7]Riessman, *op. cit.*

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The clients came for help with a variety of stated problems: marital, parent-child, situational, and emotional. The clients were assigned to one of the three counselors as openings were available in his schedule. After the first interview the client was requested to remain to take a battery of tests. These were not given before the interview for a number of reasons. Foremost was the requirement to not interfere with the process of counseling and providing immediate intakes. Moreover, the questions on goals could be understood and scored more accurately after the initial interview. The tests administered were the Taylor-Johnson Temperament Analysis test as well as a mimeographed instrument using the semantic differential technique for the client to evaluate himself on twenty-four personality traits. The traits were represented by antithetical adjectives (e.g., Tense-Calm) separated by a line. The client marked the line to indicate where he evaluated himself to be between the two adjectives. The client marked the twenty-four adjectives both for how he felt as he took the test and for how he hoped to feel "four weeks from today if counseling is successful."[8] The mimeographed instrument also asked the client's evaluation of the degree he would select among four preferred outcomes (goals) and five preferred approaches (techniques). The client was also asked to indicate the presenting problem, his estimate of how effective the counseling would be, and the social class which he felt he belonged to.

The counselor scored the mimeographed instrument for each client,

[8]See Appendix B for all the questions.

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following special instructions to indicate the degree to which he would select among the goals and techniques for the client.

After four more counseling sessions the testing procedure was repeated with the identical T-JTA test and a similar mimeographed instrument. The follow-up mimeographed instrument used the same twenty-four adjectives to evaluate the client's estimate of his feelings. Then the client checked the twenty-four adjectives a second time to indicate his ideal self, without the limiting time factor of the first questionnaire. The instrument also asked the degree to which the client felt the counselor had extended the preferred goals and techniques. Questions were also asked to ascertain what degree of help had been received, whether the presenting problem had changed, and if the client perceived himself as more responsible for the problem than he had when beginning counseling. The counselors also scored the follow-up instrument for each client.

Since the research was not trying to measure the difference between persons receiving counseling and persons not receiving counseling, no non-counseling control group was utilized. Instead the research utilized the principle of control by contrast groups on the basis of goal congruence and socioeconomic status.

Goal congruence scores were determined by the clients by measuring the difference between the client's and the counselor's score on each of the goals and techniques. A value of one was assigned for each half inch from the left margin of the 3-1/2 inch line between agreement and disagreement with the goal or technique. The differences

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were squared and summed according to Cronbach's D Square technique. The high and low congruence subgroups were compared on the outcome of the tests and on the four socioeconomic status factors in order to test the two major hypotheses: 1) high goal congruence is related to more successful counseling, and 2) working-class and lower-class clients have lower goal congruence. The results showed that the first hypothesis could be accepted statistically on the basis of the continuation in counseling of the high goal congruence clients for at least four sessions. The results of the scores on the T-JTA and the semantic differential instrument indicated that there might be some further reason for accepting the relation between goal congruence and success in counseling.

The second hypothesis was not accepted since the results showed that only one of the socioeconomic status factors (occupation-level) was related to goal congruence in a statistically significant way. This may suggest that occupation-level is one of the more stable and reliable indicators of socioeconomic status or that an individual's type of occupation affects him in many ways not directly related to the work itself. The remaining three socioeconomic status factors were not related to goal congruence in a statistically significant way.

Finally, the results of the research were discussed. The possibility exists that goal congruence is a more important predictor than socioeconomic status for the effectiveness of counseling. Although insight-oriented counselors have long indicated that goals and techniques desired by the client are a disguise for their deeper

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unwillingness to be helped, this dissertation has emphasized the importance of taking the client's choice of goal and technique as probably valid for the present time. The results of this research indicated that clients with a low goal congruence score tend to drop out of counseling early more often than clients with a high goal congruence score. Therefore, we see empirical evidence of the importance of the counselor being open to the possibility of accepting the goals and techniques desired by the client. At the very least it would stand to reason that this should be done until the client was committed to continuing in the process of counseling for a sufficient number of sessions to be helped.

The results of the research further indicated that Family Service agencies can improve their service by offering a wider variety of goals and techniques for the client to choose from. A one modality approach to counseling is self-limiting. Not only does it reduce the possibilities for effective intervention, it also tends to discourage clients who sense that the counselor will not help them gain the goal they state they desire. The client who senses the goal disparity may interpret it as a lack of respect for him by the counselor. He may interpret it as a struggle or battle of wits for which he is unwilling to pay the fee. On the other hand, the client who is anxious or depressed without knowing the cause or how he desires to be helped would not be a low goal congruence client. He would state his confusion and his desire for the counselor to provide help needed as the counselor is best able to do.

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The counselor should be open to a variety of value systems rather than biased to accept those that fit his own socioeconomic status system. The counselor must be trained and must continue to grow in his understanding and appreciation of the values and goals of the different classes and types of individuals he attempts to help.

The goal should be selected to fit the ego-strength and the growth potential of the individual. Not every individual needs or is able to utilize depth or dynamic aspects of counseling. Many clients may benefit more from counseling that attempts to assist them in resolving situational and interpersonal difficulties. There is no substantiation for believing that their problems are related to personality or emotional inadequacies in every case.

At present there is probably no better judge of the value of the counseling to the person than the client himself. The goal selected should be one that is valued by the client. Therefore, there is a need for counselors to utilize many of the counseling approaches available. There are a variety of clients experiencing a variety of problems and able to benefit best from counseling that is tailored to their needs and abilities.

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APPENDIXES

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APPENDIX A

INTAKE APPLICATION FORM

FAMILY SERVICE ASSOCIATION OF POMONA
746 North Gordon - Pomona - 623-6751

Application Form

Date_____

Last Name_____ Religion_____

Man_____
(First Name) (Date of Birth) (Education) (Home Phone)

Woman_____
(First Name) (Date of Birth) (Education) (Home Phone)

Address_____
(Street) (City and Zip)

Marital Status: Married Widowed Single Marriage Date_____
(Circle One) Divorced Separated Other Prev. Marr.: Hus.___Wife___
If Divorced, When_____

Children at Home

Name	Sex	Birth Date	School	Name	Sex	Birth Date	School

How did you learn about Family Service?_____

Will both husband and wife come for interviews?_____

Can you come to the office for appointments between 9-5 on weekdays?____

Do you need an evening appointment?_____Specify hours_____

Have you had counseling or psychotherapy before?_____

If so, when?_____Where?_____

Man's employer_____City where he works_____Position_____

Woman's employer_____City where she works_____Position_____

Salary before deductions: Husband_____Wife_____

Other income (Public assistance, pension, child support, etc.) $_____

Explain_____

What are the problems with which you hope to get help through counseling?
(Use back of page if you need more room)

_____
Completed By

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APPENDIX B

INITIAL QUESTIONNAIRE

Name_____ Date_____

Your cooperation in taking this test will help the Family Service Association of Pomona give the best service possible. Let us thank you in advance for your help. Most of the questions can be answered by placing a mark at the point on each line between words to best describe your feelings. Make one and only one mark for each line. Move through the test as quickly as you can without sacrificing accuracy. Your first reaction is probably your true feeling about each coice, so you need not take time to ponder each choice.

I. Make a mark on each line to describe how you feel *now*. If you feel strongly one way make the mark closer to that side of the line. If you feel neither is stronger make your mark near the center.

1.	TENSE	_____	CALM
2.	PESSIMISTIC	_____	OPTIMISTIC
3.	KIND	_____	CRUEL
4.	SOCIALLY ACTIVE	_____	SOCIALLY INACTIVE
5.	AFFECTIONATE	_____	UNAFFECTIONATE
6.	UNSYMPATHETIC	_____	SYMPATHETIC
7.	STRONG	_____	WEAK
8.	LOGICAL	_____	ILLOGICAL
9.	INSECURE	_____	SECURE
10.	TOLERANT	_____	INTOLERANT
11.	PASSIVE	_____	ACTIVE
12.	METHODICAL	_____	DISORGANIZED
13.	NERVOUS	_____	COMPOSED
14.	DEPRESSIVE	_____	LIGHTHEARTED
15.	SOCIALLY INVOLVED	_____	SOCIALLY UNINVOLVED
16.	SUCCESSFUL	_____	UNSUCCESSFUL
17.	EXPRESSIVE OF FEELINGS	_____	EMOTIONALLY INHIBITED
18.	SENSITIVE	_____	INSENSITIVE
19.	SUBJECTIVE	_____	OBJECTIVE
20.	SERIOUS	_____	HUMOROUS
21.	DOMINANT	_____	SUBMISSIVE
22.	CRITICAL	_____	ACCEPTING
23.	CALM	_____	EXCITABLE
24.	SELF-DISCIPLINED	_____	IMPULSIVE

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II. Make a mark on each line to indicate how you hope to feel four weeks from today if counseling is successful.

1.	TENSE	_____	CALM
2.	PESSIMISTIC	_____	OPTIMISTIC
3.	KIND	_____	CRUEL
4.	SOCIALLY ACTIVE	_____	SOCIALLY INACTIVE
5.	AFFECTIONATE	_____	UNAFFECTIONATE
6.	UNSYMPATHETIC	_____	SYMPATHETIC
7.	STRONG	_____	WEAK
8.	LOGICAL	_____	ILLOGICAL
9.	INSECURE	_____	SECURE
10.	TOLERANT	_____	INTOLERANT
11.	PASSIVE	_____	ACTIVE
12.	METHODICAL	_____	DISORGANIZED
13.	NERVOUS	_____	COMPOSED
14.	DEPRESSIVE	_____	LIGHTHEARTED
15.	SOCIALLY INVOLVED	_____	SOCIALLY UNINVOLVED
16.	SUCCESSFUL	_____	UNSUCCESSFUL
17.	EXPRESSIVE OF FEELINGS	_____	EMOTIONALLY INHIBITED
18.	SENSITIVE	_____	INSENSITIVE
19.	SUBJECTIVE	_____	OBJECTIVE
20.	SERIOUS	_____	HUMOROUS
21.	DOMINANT	_____	SUBMISSIVE
22.	CRITICAL	_____	ACCEPTING
23.	CALM	_____	EXCITABLE
24.	SELF-DISCIPLINED	_____	IMPULSIVE

III. On the following statements we want you to make a mark on the line below each statement which shows what you believe. One end of the line will stand for "Strongly Agree" and the other end will stand for "Strongly Disagree." Please choose the point on the line which corresponds to the way you feel. NOTE: "Strongly Agree" and "Strongly Disagree" are not always on the same end of the line. Please be careful to note which end you are marking and do so with a slash (/) which cuts the line at a point equal to the extent of your agreement.

Below are a series of things that people say they want through counseling. You may not want help with all of these. Indicate by a slash (/) the degree to which it is your goal.

1. I want to learn how to control my spouse (or child).

   Strongly Agree /_____/ Strongly Disagree

2. I want advice on how to improve my situation in work and/or school and/or home.

   Strongly Disagree/_____/ Strongly Agree

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3. I want to learn how to make my spouse (or child) behave better.

   Strongly Disagree /_____/ Strongly Agree

4. I want to learn how to understand my own feelings.

   Strongly Disagree /_____/ Strongly Agree

5. I want to look at my life history to find why I act and feel the way I do.

   Strongly Agree /_____/ Strongly Disagree

6. I want to find how to communicate my feelings and opinions more clearly.

   Strongly Disagree /_____/ Strongly Agree

7. I want to find and solve the problems in my relationships with the important people in my life.

   Strongly Agree /_____/ Strongly Disagree

8. I want to learn how I can change myself to make things better at work and/or school and/or home.

   Strongly Disagree /_____/ Strongly Agree

IV. Below are a series of ways that people want the counselor to work with them. Indicate with a slash (/) the degree to which each statement fits the way you want to be helped.

1. I want the counselor to listen to me and restate my observations and feelings.

   Strongly Agree /_____/ Strongly Disagree

2. I want the counselor to ask questions and suggest how I can handle my life better.

   Strongly Disagree /_____/ Strongly Agree

3. I want the counselor to ignore my emotions and help me to solve my problems objectively.

   Strongly Disagree /_____/ Strongly Agree

4. I want the counselor to encourage me to express my feelings and find how I can improve some of my personal traits.

   Strongly Agree /_____/ Strongly Disagree

5. I want the counselor to help me improve my communication with a person important to me.

   Strongly Agree /_____/ Strongly Disagree

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V. Please mark each question below.

1. I believe that counseling will help me with my problem.

   Strongly Agree /_____/ Strongly Disagree

2. If you were asked to use one of these names for your social group, which would you belong to?

   _____ Upper Class

   _____ Upper Middle-Class

   _____ Lower Middle-Class

   _____ Working Class

   _____ Lower Class

3. The problem I am seeking help for is:

   _____ Marital problem

   _____ Problem with child's behavior

   _____ Personal problem in school or work

   _____ Problems with own emotions

   _____ Uncertain about problem

   _____ Other (specify) _____

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APPENDIX C

FOLLOW-UP QUESTIONNAIRE

Name_____ Date_____

Your cooperation in taking this test will help Family Service Association of Pomona give the best service possible. Let us thank you in advance for your help. Most of the questions can be answered by placing a mark at the point on each line between words to best describe your feelings. Make one and only one mark for each line. Move through the test as quickly as you can without sacrificing accuracy. Your first reaction is probably your true feeling about each choice, so you need not take time to ponder each choice.

I. Make a mark on each line to describe how you feel *now*. If you feel strongly one way make the mark closer to that side of the line. If you feel neither is stronger make your mark near the center.

1.	TENSE	_____	CALM
2.	PESSIMISTIC	_____	OPTIMISTIC
3.	KIND	_____	CRUEL
4.	SOCIALLY ACTIVE	_____	SOCIALLY INACTIVE
5.	AFFECTIONATE	_____	UNAFFECTIONATE
6.	UNSYMPATHETIC	_____	SYMPATHETIC
7.	STRONG	_____	WEAK
8.	LOGICAL	_____	ILLOGICAL
9.	INSECURE	_____	SECURE
10.	TOLERANT	_____	INTOLERANT
11.	PASSIVE	_____	ACTIVE
12.	METHODICAL	_____	DISORGANIZED
13.	NERVOUS	_____	COMPOSED
14.	DEPRESSIVE	_____	LIGHTHEARTED
15.	SOCIALLY INVOLVED	_____	SOCIALLY UNINVOLVED
16.	SUCCESSFUL	_____	UNSUCCESSFUL
17.	EXPRESSIVE OF FEELINGS	_____	EMOTIONALLY INHIBITED
18.	SENSITIVE	_____	INSENSITIVE
19.	SUBJECTIVE	_____	OBJECTIVE
20.	SERIOUS	_____	HUMOROUS
21.	DOMINANT	_____	SUBMISSIVE
22.	CRITICAL	_____	ACCEPTING
23.	CALM	_____	EXCITABLE
24.	SELF-DISCIPLINED	_____	IMPULSIVE

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II. Make a mark on each line to indicate how you would like to feel at your best:

1.	TENSE	_____	CALM
2.	PESSIMISTIC	_____	OPTIMISTIC
3.	KIND	_____	CRUEL
4.	SOCIALLY ACTIVE	_____	SOCIALLY INACTIVE
5.	AFFECTIONATE	_____	UNAFFECTIONATE
6.	UNSYMPATHETIC	_____	SYMPATHETIC
7.	STRONG	_____	WEAK
8.	LOGICAL	_____	ILLOGICAL
9.	INSECURE	_____	SECURE
10.	TOLERANT	_____	INTOLERANT
11.	PASSIVE	_____	ACTIVE
12.	METHODICAL	_____	DISORGANIZED
13.	NERVOUS	_____	COMPOSED
14.	DEPRESSIVE	_____	LIGHTHEARTED
15.	SOCIALLY INVOLVED	_____	SOCIALLY UNINVOLVED
16.	SUCCESSFUL	_____	UNSUCCESSFUL
17.	EXPRESSIVE OF FEELINGS	_____	EMOTIONALLY INHIBITED
18.	SENSITIVE	_____	INSENSITIVE
19.	SUBJECTIVE	_____	OBJECTIVE
20.	SERIOUS	_____	HUMOROUS
21.	DOMINANT	_____	SUBMISSIVE
22.	CRITICAL	_____	ACCEPTING
23.	CALM	_____	EXCITABLE
24.	SELF-DISCIPLINED	_____	IMPULSIVE

III. On the following statements we want you to make a mark on the line below such statement which shows what you believe. One end of the line will stand for "strongly agree" and the other end will stand for "strongly disagree." Please choose the point on the line which corresponds to the way you feel. NOTE: "strongly agree" and "strongly disagree" are not always on the same end of the line. Please be careful to note which end you are marking and do so with a slash (/) which cuts the line at a point equal to the extent of your agreement.

Below are a series of things the people say that they get through counseling. You may not have gotten all these. Indicate by a slash (/) the degree to which you received each.

1. I learned how to control my spouse (or child).

   Strongly Agree /_____/ Strongly Disagree

2. I got advice on how to improve my situation in work and/or school and/or home.

   Strongly Agree /_____/ Strongly Disagree

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3. I learned how to make my spouse (or child) behave better.

   Strongly Disagree /_____/ Strongly Agree

4. I learned how to understand my own feelings.

   Strongly Disagree /_____/ Strongly Agree

5. I looked at my life history and found why I act and feel the way I do.

   Strongly Agree /_____/ Strongly Disagree

6. I learned how to communicate my feelings and opinions more clearly.

   Strongly Disagree /_____/ Strongly Agree

7. I found and solved the problems in my relationships with the important people in my life.

   Strongly Agree /_____/ Strongly Disagree

8. I learned how I can change myself to make things better at work and/or school and/or home.

   Strongly Disagree /_____/ Strongly Agree

IV. Below are a series of ways that counselors work with people. Indicate with a slash (/) the degree to which each statement fits the way you were helped.

1. The counselor listened to me and restated my observations & feelings.

   Strongly Agree /_____/ Strongly Disagree

2. The counselor asked questions and suggested how I can handle my life better.

   Strongly Disagree /_____/ Strongly Agree

3. The counselor ignored my emotions and helped me to solve my problems objectively.

   Strongly Disagree /_____/ Strongly Agree

4. The counselor encouraged me to express my feelings and find how I can improve some of my personal traits.

   Strongly Agree /_____/ Strongly Disagree

5. The counselor helped me improve my communication with a person important to me.

   Strongly Agree /_____/ Strongly Disagree

V. Please mark each question below.

1. I believe that counseling helped me with my problem.

   Strongly Agree /_____/ Strongly Disagree

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2. The main problem seemed to change during counseling.

   Strongly Agree /_____/ Strongly Disagree

3. During counseling I saw the problem more as my own and less a problem with other's behavior.

   Strongly Agree /_____/ Strongly Disagree

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